Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Nearmon Ellsworth Barrett, Jr. 10:00 P M 28 2009 Mav /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Carroll Golden Living Center Westminster If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 8. Date of Birth (Month, Day, Dec. 5, 7. Age (In yrs. last birthday, **Funeral** Months Days Hours 214-20-3302 1 X M 2 □ F 88 Yrs. 1920 **Director** Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at New Windsor Maryland Carroll 1 ☐ Yes 2 X No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code United States 2000 Old New Windsor Road 21776 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No WW II If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 □Yes 2 X No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) specialty wire inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be . Pages 1 and 2 should be fill thent of Health and Mental Hant: If item 27 Is marked oth lury or other traumatic even Tersa Pearl Byrd Nearmon Ellsworth Barrett, Sr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2000 Old New Windsor Road New Windsor, MD 21776 Joseph W. Barrett - son 20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Grove Cemetery 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Important: If it
any Injury or o June 1, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Parkton, Maryland 4 □ Donation 5 □ Other (Specify) 2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eline Funeral Home Hampstead, Maryland 21074 934 South Main Street M00741 semme Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** metastatic pros disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the for use as attending IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) the detached 9 Unknown 9 Unknown ģ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 □ Yes funeral director, page 2 should Completed peen s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed death? certificate 2 **W**No 1 🗆 Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After 1 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a

To the Funeral Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

WJL SHVA State

DHMH 17 Rev 1/2001

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

HITRACHEDU

90

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAGANNA

32. Registrar's Signature

ORIGINAL

, mid

29c. License number

D18200

TOOA POOLE ROAD WESTMINSTER.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** CARTER 01 09 ManLES /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S 7011 DOWER HOUSE ROAD UPPER MARLBORO If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day,) FEB. 16 5. Social Security Number 7. Age (In yrs. last birthday) Year **Funeral** 12 M 2 F Yrs. 1932 MARYLAND Director 220-24-0627 Usual Residence of Decedent 10d Inside City Limits with the Maryland 10c. City, Town or Location 10b. County 10a. State 28e-f ehow itam 27 is marked other then "natural", or items 23a or 28e-1 ehov other traumatic event, the Madical Examinar must be notified at 1X Yes 2 No Director UPPER MARLBORO MD PRINCE GEORGE'S 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7011 DOWER HOUSE ROAD 20772 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If itam 27 is marked other then "natural", or items 23a any injury or other traumatic event, It is Marical Examiner research. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) POSTAL POLICE OFFICER GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **EVANS GEORGIANNA HARVEY** CARTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772 19a. Informant's Name/Relationship (Type, Print) 7011 DOWER HOUSE ROAD UPPER MARLBORO, MARYLAND LYNN M. ANDERSON CARTER/WIFE 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State RESURRECTION CEMETERY 6/8/2009 CLINTON, MARYLAND J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 620 **Physician** disease or condition resulting in death) /Medical Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): nding physicien Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 Probably 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of 24a. Was an prior to co death? 1 \(\sum \text{Yes} autopsy perform 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director, After this condition MANDA 26. Place of Death Check onl one 25. Was case referred to medical examiner DICE Hospital: Other: Other (Specify) 1 ☐ Yes 2 Z No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28d. Describe how injury occurred 28c. Injury at Work? Date of Injury (Month, Day Year) 28b. Time of Certification: 27. Manner of Death 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and fine of certifier 29c. License number R10

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State Registrar 32. Registrar's Signature

INV

DEYENSE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2009 2:10 May 26. Vickv L. Carden /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Doctors Hospital Lanham Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours 1 ☐ M 2 🖫 F 28,1953 West Virginia 55 225-80-9052 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be netitled at 1 □XYes 2 □ No Director Maryland Prince Georges Seabrook 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20706 U.S.A. 9753 Good Luck Rd. Funeral 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 □Yes 2K No Specify. þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Room Store 12 Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental h Ray Armstrong Betty Sandridge ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Good Luck Rd. Seabrook, MD 20706 Charles Carden (Husband) of Health a item 27 is Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If itel any injury or otl 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 5/29/09 Beltsville, Maryland Chesapeake Crematory 5 ☐ Other (Specify) 4 ☐ Donation 21. Signature of Funeral Service Licens 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute Hypoxia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Else of Cause (Disease or injury that initiated events resulting in death) Last Acute Anemia Due to (or as a consequence of) Physician/Medical Examiner requires that the death certificate be executed Liver Cirrhoses and burial-trar Due to (or as a consequence of) the as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav in the past 12 months? 1 ☐ Yes 2 💆 No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 ☐ Yes 2 ☐ No certificate 1X Yes 2 □ No Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director. Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X npatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Division of this After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1X Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Decretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Decretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier (Check only one) and manner stated within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 06/03/09 D52500

Registrar

Fozia

ahahe 31. Date filed (Month,

8118 Good huck Rd., Lanham, MD. 20106

pleted cause of death (Item 23a) (Type, Print)

mi).

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2009 Physician 2:30 P M June 2, Sylvia Reeves Crosby /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery 6005 Henning Street Bethesda Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Sept 21, 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Months Days Hours 1930 England 1 □ M 2 💢 F 412-98-8558 78 Director Usual Residence of Decedent filed within 72 hours after death with the Marytand 10d. Inside City Limits 10a. State 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Evantions must be notified at 1 ☐ Yes 2X No Director Bethesda MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number England 6005 Henning Street 20817 Funeral 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 □Yes 2 No Specify: White Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Computer Technology Administrative Assistant permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 Is marked other I any injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jessie Margaret Leslie Thomas Harold Reeves 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6005 Henning St. Bethesda, MD 20817 A.C. Crosby/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Final Journey Crematory 06/04/09 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Golfman Homes Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Pancreatic Carcinoma 10 months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year fo in the past 12 months? 1 ☐ Yes 2 ▼No Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by to be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? 1 Yes 2 ANO certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of coatifier June 3, 2009 D23308 30. Name and address of person the completed cause of death (Item 23a) (Type, Print)
Victor M. Priego, M.D. 6420 Rockledge Drive Suite 4100 Bethesda, MD 20817 32. Legistrar's Signature JUN 0 4 2009 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 9505 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 Year **Physician** JÜNE 11 5:29A M WALTER GLENN DURST /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2324 HAWKS LANDING CT. CHARLES WALDORF If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 8-11-1941 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 € M 2 □ F OHIO 67 282-36-8438 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show MD. CHARLES 1 ☐ Yes 2 XNo WALDORF 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Examinant nation once. 2324 HAWKS LANDING CT. 20601 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ^{2□}^N984^V¥5 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE ≥ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry CUYAHOGA FALLS Elementary/Secondary (0-12) 12th College (1-4or 5+) POLICE-OHIO POLICE OFFICER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LELAND DURST LOUISE CLARK 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOY DURST-SPOUSE 2324 HAWKS LANDING CT. WALDORF, MD. 20601 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ME METROPOLITAN CREMATORY 6-14-09 ALEX., VA. 2. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A. 21. Signature of Funeral Service Licens M0.0479 LA PLATA, MD. 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SPIRATION DNEUMONIA 12009 /Medical Due to (or as a consequence of): Examiner 10+ Rophic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nsequence of) Examine or Attending Physician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>გ</u> 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1 ☐ Yes 2 XNo To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Physician D 6643 Name and address of person who completed cause of death (Item 23a) (Type, Print) Washington Road #103 Waldorf mp 20602 hass 31. Date filed (Month, Day, Year) State **JUN 17** Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** PM MARY JANE DAVIS JUNE 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HARL MEDICAL CENTER 8. Date of Birth 6 (Month, Pay 204) 9. Birthplace (State or Foreign Social Security Number **Funeral** Days Hours Months 1 □ M 2√□ F NEW YORK 117-18-0272 85 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, It. Medical Example and once. 1 ☐ Yes 2 No CHARLES Director MD. WALDORF 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20601 12244 WENDY LANE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: WHITE 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WALTER HEARN TERESA REDMAN ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MARY E.HOGAN-DAUGHTER 12244 WENDY LANE WALDORF, MD. 20601 9115, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 X Cremation 3 Removal from State METROPOLITAN CREMATORY 6-11-09 ALEX., VA. 4 ☐ Donation 5 ☐ Other (Specify) M00479 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 20646 21. Signature of Saneral Service Licenses Hic 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ORUN walks **Physician** in /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine KUKS certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) signed by the a d be detached f 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform this certificate 1 ☐ Yes 1 ☐ Yes 2 🗆 No To the Hospital or Attending Physiclan: Within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director. D 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 000 Hospital 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division (Month, Day, Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical The first control of the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintenance and place, and due to the cause(s) and maintenance stated.

■ Medical Examiner: On the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and maintenance stated. 29d. Date signed (Month, Day, Year) d title of certifier 29c. License number 29b. Signature

State Registrar 32. Registrar Signaty

State of Maryland / Department of Health and Mental Hygiene, for State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Natalie Malida Denkowski 735 M May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner REGIONAL HICOMIC CONTE 39/13/144 POICAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day. **Funeral** Vear Days Hours Min. 206-20-5685 1 □ M 2 □ **x**F 83 Months 07/13/1925 Pennsylvania Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature!" any injury or other traumatic exercises. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 Yes 2 No Director Wicomico Salisbury Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21801 USA 820 Tressler Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No 1 ☐ Yes 2 ☐ XNo Specify: white If Yes, Give Completed by Specify: 3 Widowed 4 ☐ Divorced Year or Dates: 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) domestic 12 housewife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Suzanne Ertner Rzepczynska Frank ပ္ 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 5051 Stansfield Dr., Zionsville, PA 18092 19a. Informant's Name/Relationship (Type. Print) Walter Denkowski/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/1/09 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Salisbury, MD 22. Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 eral Service Licensee Holloway Funeral Home Profes 501 Snow Hill Rd., Salisbury 23a. Part1. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Lyny (4 h 6 v disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ICH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) signed by the attending physician at the burial Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown peen Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed After this certificate 2 No 2 No 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To nours after death.

neral Director: After this filled in by the funeral di 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral [29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shew NATESAN 1415 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Dav Eliza Eshelman June 1, 2009 8:07 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert Calvert Memorial Hospital Prince Frederick If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🛣 F New Jersey 151-14-1483 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Calvert Lusby 10f. Zip Code 10g. Citizen of What Country? 20657 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) Lydie Wells 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12178 Preston Dr. Lusby, MD 20657 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State

Department of Health and Mental Hygie Important: If Item 27 Is marked other I any injury or other traumatic event, th once.

Physician

/Medical

Examiner

Funeral

Director

28a-f show must be notified at

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Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

page 2 s After thi funeral

I Director: / d in by the fi

he law requires that the death certificate be executed or Attending Physician: within 24 hours aft

To the Funeral Di

completely filled in the Hospital

Division or Vital Records, P.O. Box 68760,

Examine Physician/Medical þ Completed Be မ Certification:

Usual Residence of Decedent 10a. State Director MD 10e Street and Number 12125 Preston Drive Funeral 11 Marital Status 1 Never Married 2 Married þ 3 XWidowed 4 ☐ Divorced Completed Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Be Robert Ellsworth Bozarth 19a. Informant's Name/Relationship (Type. Print) Ralph E. Eshelman/son 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Final Journey Crematory 06/04/09 Woodbine, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral-Service Licen Going Montes Crestlation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hemon ha days Due to (or as a consequence of): Sequentially list conditions, if any maxima influence cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? 1□ Yes 2⊠No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Mertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MI Allau D67647

State Registrar CALVERT

31. Date filed (Month,

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parke

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOSPITAL

32. Pegistrar's Signature

Iram Khan

-, 100 HOSPITAL ROAD, PRINCE FREDERICK, MD

			For State Registrar	State of Maryla		rtment of h			jiene 200	9 19509
	Dharisi		1. Decedent's Name (First, Middle, Last)					2. Date of Deat MAY 3	- 1/-	3. Time of Death 3 26P M
	Physicia /Medic		CALVIN		HOLLAND	45 City Taylor o	a Legation of Dooth		4c. County of De	
	Examin	er	4a. Facility Name (If not institution, give s WASHINGTON ADVE		AL	TAKOMA	r Location of Death PARK	1	MONTGO	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. I	Birthplace (State or Foreign Country)
	Director		213-84-2591	M 2□F 47	Yrs.	Months Days	Hours Willi.	SEPT Day	1961 _{MA}	RYLAND
	m w		Usual Residence of Decedent 10a. State 10b. County	10c, C	City, Town or Lo	cation				10d. Inside City Limits
	Marylk f sho	ğ	MD PRINCE G	EORGE'S	MITCHE	LLVILLE				1 XYes 2 □ No
	r 28a	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	th with	al	17010 QUEEN ANNE	BRIDGE ROAD		207			USA	
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wedical Experience must be notified at	by Funeral Director	11. Marital Status 1 □ X Lever Married 2 □ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Nas Decedent of h fYes, specify Cub I∐Yes 2∄No	Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- to Rican, etc.)	Black, W	merican Indian, hite, etc. BLACK
2-0	72 ho	eted	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occup	during most of wor	rking	16b. Kind of Busine	ss/Industry
121	/ithin	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		RESOURC	E SPECIAI	LIST	PRIVATE	
d 2	filed within Hygiene. other than " ent, the Me		17, Father's Name (First, Middle, Last)		Holan	REBOUTE			Maiden Surname)	
/lan	should be tind Mental marked o	To Be	ALFRED HOLLAND				GERTRUI			
, Maryland 2121	1 and 2 sho Health and I tem 27 Is ma other trauma	•	19a. Informant's Name/Relationship (79), DEBBIE HOLLAND TA	pe. Print) RPLEY / SISTER	19b. Mailir 1701	ng Addrøss (Street O QUEEN	t and Number or Ro ANNE BRII	oral Route Numbe		e Zip Code) 7 ILLE, MARYLANI 20716
Baltimore,	Pages 1 and the properties of		20a. Method of Disposition 1	amoval from State	cemetery, crer	sition (Name of natory or other pla T MEMORI.	ce) AL 6/8/	Date / 2009		S, MARYLAND
Balti	permit. Pages 1 Department of H Important: If Ite any Injury or ot once.		21. Signature of Funeral Service License	00		2. Name and Addre	•		ENKINS FUN ER,MARYLAN	NERAL HOME ND 20785
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oʻ	icate be executed physician and the burlal-transit	Exa	resulting in death) Last	Due to (or as a conse	equence of):					
8760,	ate be hysici the bu	dical								
O. Box 6	ath certif attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time o 9 □ Unknown	etal death 3	☐ Ectopic pregnan ☐ Other (specify) _			23d. Date of Month	delivery Day Year
σ.	uires that the de signed by the d be detached i		Part II. Other significant conditions cor	tributing to death but not re	esulting in the u	nderlying cause gi	ven in Part I.	23e. Did to	obacco use contribu	te to the cause of death?
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Division of Vital Records,	The law requir cate has been s page 2 should l	Completed	C. diff Co	slitis					osy prior rmed? deat	e autopsy findings available r to completion of cause of h? Yes 2£ No
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o uo	Jing F	tion:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Wo	uryat ork? ⊒Yes 2 ⊒No	28d. Describe I	now injury occurred	
Divisi	声름호	Certification: To	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, st	eet, factory, office		28f. Location (8 City or Tox	Street and Number o	or Rural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical C	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Exami	sician: To the best of my k ner: On the basis of exam and manner stated.	nowledge, dea ination and/or in	th occurred at the nvestigation, in my	time, date and place opinion, death occ	ce, and due to the curred at the time,	cause(s) and mann date and place, and	er as stated. due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier 29 Social	mD			30 05		29d. Date signed (A	Nonth, Day, Year)
	4		30. Name and address of person who co	ompleted cause of death (I						
14	- 1		Jennifer Gnul			7600 CARI	ROLL AVEN	UE TAKOM	IA PARK, MA	RYLAND 20912_
	Sta Regist		JUN 0 4 2009	32. Hegistrars Sig	nature		<u> </u>			

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last, 3. Time of Death Month Year 1644 **Physician** lizabeth Mai 200 /Medical 4b. City, Town, or Location of Death Baltmore 4c. County of Death 4a. Facility Name (If not institution, give street and number Examiner University Marvland Medical Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Months Days Hours 1□ M 25 F Director 67 July 02 1941 175-34-3969 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, Ite Modical Examinat must be notified at any injury or other traumatic event, Ite Modical Examinations must be notified at appear. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☑ No Director York PA York 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 17403 USA 660 Cortland Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 28 Married Baltimore, Maryland 21215-0036 1 □Yes 2 □Xo Specify. \$ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Erlene Ahrens Dr. Llewellyn R. Heisler ဨ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barry R. Hengst/husband 660 Cortland Drive York, Pa 17403 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State South Carroll Crematory 6/2/2009 Winfield, MD 4 ☐ Donation _5 ☐ Other (Specify) nature of Fu Princes of the and Chapel, P.A. 412 Washington Road Westminster, MD 21157 Approximate Interval Between Onset and Death 23a. Part. Enter the lease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ure. List only one cause on each line. shock, or heart failure. Immediate Cause (Final **Physician** od-71mo disease or condition resulting in death) /Medical Due to (or as a consequence Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed pper burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending p yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐Yes 2 ☐ No sate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions, contributing to death but not resulting in the underlying cause given in Part I. ð 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No after death.

Director: After this certifical in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1.⊠npatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide lled 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical within 24 hor To the Fune completely fi and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier P22070

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Registrar
DHMH 17 Rev 1/2001

Greene

30. Name and/address of person who completed cause of death (Item 23a) (Type, Print)

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JUN 03

31. Date filed (Month, Day, Year)

Poursharit

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month P^{M} 10:40 Ruth Ingaborg Elizabeth Johnson Hegyeli 2009 June 1. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery General Hospital 01ney Montgomery 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Days Months Hours 1 □ M 2 🛛 F 14, 1931 Sweden 033-36-0501 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No Maryland Montgomery Gaithersburg 10g. Citizen of What Country? 10f. Zip Coda 10e. Street and Number USA 20882 24301 Hanson Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 X No Specify 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Director for International Prog. 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) National Institutes Elementary/Secondary (0-12) College (1-4or 5+) 5+ of Health Nat'l. Heart, Lung & Blood Inst. 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Elsa Elizabeth Sjogrun John Alfred Johnsson 19a. Informant's Name/Relationship (Type. Print) brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 464 Bayshore Drive, Martinsburg, West Virginia 25404 Pehr Perry Joseph Johnsson, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metropolitan Crematory 6/2/2009 Alexandria, Virginia 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Molesworth-Williams Funeral Home Signature of Fundamental Sen 26401 Ridge Road, Damscus, Maryland 20872 23a. Part 1 Enter the disease, or complications that caused shock, or heat failure. List only one cause on each lib the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Sause (Final disease or condition resulting in death day Date of delivery Year ontribute to the cause of death? 3 Probably bb. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

Physician) /Medical Examiner

Physician

/Medical

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Funeral

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Examiner

Funeral

Director

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28a-f

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Department of Health and Mental Hygie Important: If item 27 is marked other any Injury or other traumatic event, It once.

traumatic event, the Medical Examinar must be notified at

the Maryland

with ō items 23a

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Physician/Medical Examiner Be Completed by Medical Certification: To

and burial-trar physician the attending pl signed by the a page 2 should been has certificate ours after death. eral Director: After this certificalilled in by the funeral director, it within 24 hou To the Fune completely fil

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, waying to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Acute Lenal failure Due to (or as a consequence of): Metastatic Carcinoid tumor Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year			
	tributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death			
		24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings avail prior to completion of causing death? 1 Yes 2 No 2 No			
25. Was case referred to medical examiner?	26. Place of Deat	h (Check only one)			
1 Yes 2 No	ospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Ho	me 5 Residence 6 Other (Specify)			
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation		28d. Describe how injury occurred			
3 Suicide 6 Could not be 4 Homicide determined					
29a. Certifier 1 CertifyIng Phys	Sleian: To the best of my knowledge, death occurred at the time, date and place,	and due to the cause(s) and manner as stated.			

and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

Name and address of person who completed cause of death (Item 23a) (Type, Print) uanbo

omer ran Mont

31. Date filed (Month, Day, Year) JUN 03 2009 Registrar's Signature

State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 29, 2009 Lottie Elizabeth Seymore Holland May /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Wicomico Salisburg Rehabilitation Nuvsing Ctr. 5. Social Security Mimber 6. Sex 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) If Under 1 Year Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min. 1□M 2XF Wicomico/MD 75 4 - 12 - 34226-36-7917 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 □X es 2 □ No Director Somerset Princess Anne MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21853 30599 Antioch Ave, Apt A Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 XNo Specify Specify: Black by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer/Cook 7th Seafood Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arentha Marshall Hilton Seymore ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Thomas J. Seymore/Son 123 Newtown Rd, Chester, MD 21619 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/6/09 Union Wesley UMC Kent Island, MD 22. Name and Address of Facility 917 W. Isabella St Sonature of Funeral Service Licenses Bennie Smith Funeral Home Salisbury, MD 21801 23a. Part1. Infer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ca Je (Final ear (E disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due for as a consequence of) Examine Due to (of as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Physician /Medical Examiner

Director

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ortant: if item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examir or must be notified at

filed within 7 I Hygiene.

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Ite IN.

. Pages 1 and 2 tment of Health 2

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

Holland

is certificate has been s director, page 2 should I မ

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Certification:

State Registrar

<u>გ</u> Completed Be

25. Was case referred to medica examiner? 1 ☐ Yes 2 40 27. Manner of Death

29b. Signature and title of certifier

29a. Certifier

(Check only

Medical

1 A Natural 5 ☐ Pending investigation 2 Accident 3 Suicide 4 Homicide

6 ☐ Could not be

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

24a. Was an autopsy performe

2 4No

1 □ Yes

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Yes 2 No 3 Probably 4 Unknown

2180

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 ☐No

29d. Date signed (Month, Day, Year) 29c. License number

26. Place of Death (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

William H. 200 M.D

31. Date filed (Month, Day, Year)

Ave. 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2009 5:20 A. June Vernice V. Johnson 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Prince George's Laurel Regional Hospital Laurel 9, Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth Days Wash., D.C. Hours Months 1 □ M 2 🔀 F 86 04/21/1923 578-28-4570 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County D.C. Washington 1X Yes 2 □ No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20019 U.S.A. 3330 Clay Pl., N.E. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 XNo 1 Never Married 2 Married Black 1 □Yes 2 No Specify: Specify 3 XWidowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) D.C.Public Schools Cafeteria Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Theodore Keys Josephine Miles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3330 Clay Pl., N.E., Washington, D.C. 20019 Aline Williams/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 06/08/09 Landover, Maryland Harmony Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility} H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 21. Signature of Funeral Service License an. 1 24 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hours Sepsis Due to (or as a consequence of): Hours Hypotension Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hours Pneumonia Due to (or as a consequence of) Years (2) Cerebrovascular Accident yes, outcome of pregnancy ☐ Live birth 2☐ Fetal death 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Year Day Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a. State

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Funeral

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2 n 24 hours aft e Funeral Di letety filled in

To the Hosp within 24 hor To the Fune completely fi

Funeral

Director

d other than "natural", or items 23a or 28a-f show event, the Medical Experience must be rectified at

7 is marked other traumatic event, if

Department of Health Important: If item 27 any injury or other troone.

Pages 1 and 2 should be filed within 72 hours after death with 1 nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or ?

Baltimore, Maryland 21215-0036

the Maryland

burial-tran attending physician for use as the buria ed by the a detached f signed I peen s certificate has birector, page 2 s director After after death.

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

23b. Was decedent pregnant in the past 12 months? ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Bedridden with Sacral Decubitus Ulcer Left Hemiparesis performed? Yes 2 No 1 ☐ Yes Contractures

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29a. Certifier (Check only TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D67418

29b. Signature and title of certifier Medica

29d. Date signed (Month, Day, Year) 29c. License number

June 2,2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Olalekan Olufemi, M.D. 7300 Van Dusen Road, Laurel, Maryland 20707

State ^{*} Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-04266 State of Maryland / Department of Health and Mental Hygiene Angelo Lee Johnson Certificate of Death Reg. No 1- For State 2. Date of Death Registrar Month Day May 28, 2009 1. Decedent's Name (First, Middle,Last) 2001 hrs Physician/ Medical Examiner ANGELO LEE JOHNSON c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly Prince Georges Hospital Center 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or ForeignWashington Country) D.C. If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min Days Hours Months 7/16/1990 Director $_{1}XM$ 2 18 578-19-6244 10d. Inside City Limits Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a. State 1 X Yes 2 No Washington 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. 10g. Citizen of What Country? DC 10f. Zip Code 10e. Street and Number United States 2643 Naylor Road SE # 201 ö 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces? 1 X Never Married Married 2 2 X No Yes Specify: Black Yes 2 X No specify: If Yes. Give Year Divorced 3 Widowed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done ⋧ 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Private 21215-0036 Unemployed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) <u>Miquitta Scott</u> Be Andre Lee Johnson Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ဥ 20020 2643 Naylor Rd. SE #201 Wash. D.C. 2 <u>Miquitta Scott</u> / Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Baltimore, Removal from State 1 X Burial 2 Cremation 3 Washington, D.C. 6/5/2009 permit. Page Department o Important: injury or oth Olivet Μt onation 5 Other Specify 22. Name and Address of FacilityPope Funeral Homes, P.A. ature of Funeral Service Licensee 5538 Marlboro Pike Forestville, Maryland 20747 Approximate Interval Shat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Between Onset and Enter the disease Physician Death failure. List only one cause on each to Multiple Gunshot Wounds and Blunt Force Trauma to Head 'Medical Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and ian/Medical AMENDED UNPENDED signed by the attending physician be detached for use as the burral 23d. Date of delivery The law requires that the death certificate be Box 68760, 23c. If yes, outcome of pregnancy Year IF FEMALE: Month Day 3 Ectopic pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) Physici 1 Yes 2 No 9 Unknown a 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions 1 Yes 2 No 3 Probably 4 Unknown ó ģ ۵. 24b. Were autopsy findings available 24a. Was an Completed Division of Vital Records, ficate has been si page 2 should b prior to completion of cause of autopsy death? performed' Yes Yes 2 1 🗸 certificate 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: Other₄ Be Residence 6 Other Hospital: Nursing Home 5 DOA Inpatient 2 V ER/Outpatient 3 this 1 🗸 Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) May 28, 2009 28b. Time of Injury Director: After t I in by the funeral Subject beaten and shot 27. Manner of Death After Certification: 1926 hrs Yes 2 ✔ No Natural 1 5 Pending hours after death. 28f. Location (Street and Number or Rural Route Number, City Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) 53rd Street and Drake Place S.E., Washington, DC Could not be 3 Suicide the Funeral Di (Specify) Yard determined 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 24 Medical 29d. Date signed (Month, Day, Year) and manner stated 29c. License number 29b. Signature and title of certifier May 29, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Donna M. Vincenti, MD 32. Registrar's Signature State 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2009 Month **Physician** May 28 10:54 A M James Leandrew Jackson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Clinton Southern Maryland Hospital Prince George's 5. Social Security Number 7, Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 x M 2 □ F 1918 Garratt, 91 **Director** 117-05-8371 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits show 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the the disal Evantivat must be notified at Temple Hills Maryland Prince George's 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20748 USA 4622 Henderson Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WWII 1 ☐Yes 2 ☐ No Specify: 2 Specify: Black 3√Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit, Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event, If a Made. Elementary/Secondary (0-12) College (1-4or 5+) Law Enforcement US Park Police Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Irene Lee Stith Walter B. Jackson ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Virginia J. McDonald -Daughter 4622 Herderson Rd, Temple Hills, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 3 ☐ Other (Specify) Clinton, MD Lee Crematory June 1, 2009 22. Name and Address of Facility 21. Signature Euperal Service Livensee Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd, Clinton, MD 20735 MO139 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ~div /Medical Due to (or as a consequence of): ~ Suliump **Examiner** 12331W Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-transit ナカナインナイン the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, signed by the attending physician I be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been si page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No 1 □ Yes To the Hospital or Attending Physician: " within 24 hours after death. To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 TYes 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** JUNE 2009 8:27 A M **EULIS** KNOX JR. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S LAUREL REGIONAL HOSPITAL LAUREL If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ F WASHINGTON, DC JAN. ĩ959 219-72-1370 50 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, in Medical Examination in the motified at 1 Yes 2 No Director MD PRINCE GEORGE'S LANDOVER the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 20785 USA 23a 3107 82nd AVENUE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 __Xes 2 __ No MARINES If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 72 hours after 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 BLACK 1 □Yes 2X No Specify: ò 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CORRECTIONAL OFFICER DC GOVERNMENT permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 Is marked other I any Injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be KNOX RUBY MCCLAIN EULIS ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3107 82nd AVENUE LANDOVER, MARYLAND 20785 **EVA** ROSS-KNOX/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HARMONY CEMETERY 6/8/2009 LANDOVER, MARYLAND 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME Signature of 7474 LANDOVER ROAD LANDOVER, MARYLAND Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): attending physician Physician/Medical the nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Day Year in the past 12 months? 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 47 ☐ Unknown been si should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be lirector, page 2 sl perform 2 ⊿No 1 ☐ Yes Attending Physician; To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 ☐ Inpatient 2 🔀 ER/Outpatient 3 ☐ DOA ဂ္ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Box 68760,

P.0.

State Registrar

7300 VAN DUSEN ROAD LAUREL, MARYLAND 20707 BURGUIERES M.D. THOMAS H. 32. Registrar's Signat

30. Name and address of person who completed cause (death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	State of Ma		artment of Health and I rtificate of Death	Reg	. No 2009	19517
	hysicia	an	1. Decedent's Name (First, Middle, Last) Lawrence A.	Ke1	lley	2. Date of Death May 31,	2009 Year	3. Time of Death 7:25 A M
	/Medic xamin		4a. Facility Name (If not institution, give street and number) Pineview Future Care		4b. City, Town, or Location of Death		4c. County of Death	eorge's
	neral ector		5. Social Security Number 6. Sex 7. Ag	je (In yrs. last birthday) 78 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.		Year) 9. Birth Cou 1930 Wes	place <i>(State or Foreign</i> <i>intry)</i> t Vírginia
ryland	thow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo				10d. Inside City Limits 1 □Yes 2 □ ☆ □ ☆
e Ma	8a-fs	ecto	MD P.G.	U	pper Marlboro 10f. Zip Code	100	g. Citizen of What Cou	
with th	a or 2	5	10e. Street and Number 10705 Wyld Drive		20772		United	States
5-0036 72 hours after death with the Maryland	If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the "Motical Experimer must be notified at	by Funeral Director	11. Marital Status 1 Never Married XX Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces? 1 YeX 2 If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Slif Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 (X)No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White Specify: W	
21215-0036 d within 72 hours aff giene,	"natural" Ndical Ex	Completed b	15, Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired)	rking 1	6b. Kind of Business/I	
d 2121 filed within Hygiene.	th.	mo;	Elementary/Secondary (0-12) College (1-4or	5+) me	chanic			rforce
nd ne filec	d othe	Be	17. Father's Name (First, Middle, Last)			me (First, Middle, M.		
yla ould b	narked natic e	၉ .	Lawrence Lynn Kelley	10h Mail	Ida Mae ling Address (Street and Number or R	Blevins		Zip Code)
;, Maryland 21 and 2 should be filed w ealth and Mental Hygie	27 is n r traun		19a. Informant's Name/Relationship (Type. Print) Althea M. Kelley (Wif	1.0	0705 Wyld Drive			
Baltimore, M Demit. Pages 1 and 2 Department of Health	Important: If Item any injury or othe once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of Disp cemetery, cre	position (Name of ematory or other place) ematory June 1		Oc. Location - City or $Clinton$,	
Baltimo permit. Page Department	Importar any injur once.		21. Signature of Funeral Service Licensee	- 2	22. Name and Address of Facility Le	e Funera		
icate be executed Examine be executed physician and physician and street because it the burial-transit	edical	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	s a consequence of): s a consequence of): s a consequence of):	HE LVW6 U	YTH VE	TASTÌCES	Onseit and Death
30x (ath certi	ttending or use a	Physician/Med		2 ☐ Fetal death 3 at time of death 5	B ☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of de Month	livery Day Year
ds, P.	signed by the and to be detached for	b	Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause given in Part I.	23e. Did tob	es 2 □ No 3 □ P	o the cause of death? robably 4 🔲 Unknown
al Records, The law requires the	cate has been page 2 shoul	Completed				24a. Was ar autops perforn 1 □ Yes 2	y prior to ned? death? 2 No 1 ☐ Yes	utopsy findings available completion of cause of s 2 No
Vision of Vital Attending Physician: Ter death.	: After this certificate has been s e funeral director, page 2 should	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 1 Inpa 27. Manner of Death 1 Natural 5 Pending (Month, December 1) 2 Accident investigation	tient 2 ER/Outpati njury 28b. Time Day, Year) Injury	ient 3 DOA Other: 4 Nursing		ence 6 Other (Spe ow injury occurred	əcify)
Division all or Attending safter death.	To the Funeral Director: completely filled in by the	Sertifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of I building,	njury - At home, farm, s etc. <i>(Specify)</i>		City or Town		
the Hospital	ne Funera	Medical C	29a. Certifier (Check only one) **Total Certifying Physician: To the besis and manner: On the basis and	of examination and/or	rinvestigation, in my opinion, death oc	curred at the time, d	ate and place, and du	e to the cause(s)
To th	To th	Me	29b. Signature and title of certifier	~ ₩	29c. License number	2	9d. Date signed (Mon	2009
J.B.	321		30. Name at all ress of person who completed cause of P-WISOVSKH McO	12070	e, Print) OC) LINE CG	WER (WALDONE	Md 2066
	Sta	ate	31. Date filed (Month, Day, Year) 32. Regis	strar's Signature	park		,	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Рм 4:00 Rosalind Carroll Landers 06 09 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h. City. Town, or Location of Death Harford Memorial Hospital Harford Havre de Grace Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) 1 □ M 2 💢 F Months Days Hours Maryland 02,08,1925 219 18 2297 Usual Residence of Decedent 10d. Inside City Limits 10a State 10h. County 10c. City. Town or Location 1 XYes 2 No Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 171 Farm Road 21001 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: White 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telecommunication 12 Marketer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dennis D. O'Leary Adelaide Egner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Maranto - Daughter 3101 Rices Lane, Baltimore, MD 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Bel Air Memorial Gdns 06,13,2009 Bel Air, MD 4 Donation 5-DOther (Specify) 22. Name and Address of Facility eral See Tarring-Cargo Funeral Home, P.A. 333 S. Parke St. Aberdeen, MD 21001 23a. Part 1. Enter the disease, a complications that caused the shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Year Day 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn 2 No 1 ☐ Yes 2 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner Examiner requires that the death certificate be executed

Department of Health a important: If Item 27 is any injury or other tra

Health

Pages 1

permit.

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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Maryland 21215-0036

Baltimore,

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Director

Funeral

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traumatic event, the Medical Examiner must be nutified at

sician and burial-trans physician the attending p signed by the page certificate After this funeral

Physician/Medical

Completed by

Be

Medical Certification: To

29a. Certifier

31. Date filed (A

29b. Signature and title of certifie

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 ☐ Unknown

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 1 Natural

5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manger stated.

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 951 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** June DOLORES MAY MYERS 009 /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner Plata Medica Charle La Conter If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖵 F 67 Yrs 9-8-1941 220-38-1976 WASH., D.C. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be redified at 1 Yes 2 No MD. CHARLES Director WALDORF 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 13323 POPLAR HILL ROAD 20601 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: Specify: WHITE ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TAX CONSULTANT H.& R.BLOCK <u> 12th</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JAMES ARTHUR YOW, II FLORENCE MAY WILDS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13323 POPLAR HILL RD. STEPHEN W.MYERS-SPOUSE WALDORF, MD. 20601 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Removal from State Cernetery, crematory or other place)
4 Donation 5 Other (Specify)

METROPOLITAN CREMATORY 6-17-09 ALEX., VA. 21. Signature of Pineral Service Licensee Name and Address of Facility M00479 RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MD. 20646 23a. Part 1. Enter the disease, or complications that cauled the death. Do not the rethe mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on thick line. Approximate Interval Between Onset and Death ASPIPATION PNEJ MONIA Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner VOTRO if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) death certificate be executed burial-transi and Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the as for use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months' 1 ☐ Yes 2 ☑ No 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Umbedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	late of Maryland	•	tificate of L		Re	eg. No.2	109	19520
П	Physicia	an	1. Decedent's Name (First, Middle, Last)	MEYERS	,			2. Date of Deat Month MAY 29,	Day 2009	Year	3. Time of Death 12:12A M
	/Medic	al	ROSALIND SANDRA 4a. Facility Name (If not institution, give street		·	4b City Town or	Location of Death	FIA1 29,		ty of Death	
	Examin	er	9526 NOTTINGHAM DR				MARLBORO			•	GEORGE'S
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Cou	place (State or Foreign intry)
	Director		055-56-4450 1□ M	2 LXI F 5	6 Yrs.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		FEB 10	1953	NEV	V YORK
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	cation					10d. Inside City Limits
(1213-UU36 within 72 hours after death with the Maryland	Maryl fed a	ţō	MD PRINCE GEOF	GE'S UP	PER MA	RLBORO					1 La Yes 2 □ No
	r 28a	irec	10e. Street and Number			10f. Zip Code		1	0g. Citizen o	f What Cou	intry?
th with	th with	al D	9526 NOTTINGHAM DRI	VE		2077			USA		
	r dea	nue	11. Wand otales	Was Decedent Ever in U.S Armed Forces?	3. \ 13. \	Vas Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp ın, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ace - Amer lack, White,	ican Indian, , etc.
30	rs afte	by Funeral Director	TT	1 ∐Yes 2 MΩNo fYes, Give Year or Dates:	1	I∐Yes 2 X No	Specify:		Spec	eify: B1	LACK
215-0036	thin 72 hours after death with the Marylan e. "natural", or items 23a or 28a-f show Mackell Evening in ust be natified at	ted	15. Decedent's Education (Specify only highest grade co		16a. Deced	dent's Usual Occup	ation	ina	16b. Kind of	Business/li	ndustry
2	thin 7:	Completed		College (1-4or 5+)		kind of work done o OO NOT use retired		ing	_		m.:
V	be filed wit ntal Hygien of other the event, the		12		CONTR	ACT SPEC	18. Mother's Nam	e (First, Middle, I		PRIVA'	IE
yland	d be fill antal F ed ot	Be c	17. Father's Name (First, Middle, Last) BUSTER B. MEYERS				ALRI		PKINS		
Ē	2 should be n and Mental is marked of raun ctic eve	ဠ	19a. Informant's Name/Relationship (Type.	Print)	19b. Mailin	ng Address (Street	and Number or Rui	al Route Numbe	r, City or Tow	ın, State, Z	ip Code)
Z Z	alth a alth a 27 is er trau		MARTELLA HOWARD/S		3704	LADD AV	ENUE FORT				
e,	es 1 a of He fitem		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem	20b. P	lace of Dispo emetery, cren	sition (Name of natory or other plac	e) ;		20c. Locatio		
Ĕ	Pagiment ment tant: I		4 □ Donation 5 □ Other (Specify)	R		CTION CE		/2009			RYLAND
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traunctic evonce.		21. Signature of Funeral Service Line see		22	2. Name and Addres	ss of Facility NDOVER RC	-			ND 20785
	2.		23a Part 1 Filler Inc. Iseas a or complicate shock, or heart failure. List in the complete shock is a second secon	ons that caused the death	n. Do not ent						Approximate Interval Between
- 1	Physician		shock, or heart failure. List only the commediate Cause (Final disease or condition	ause on each line. RESPIRAT							Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):								
	Examiner	L	Sequentially list conditions, b.			TITIAL L	UNG DISEA	.SE			-
	ted nsit	njne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	uence ot):						
	execut and al-trar	Examiner	that initiated events c resulting in death) Last	Due to (or as a consequ	uence of):	·-			-		
6876 U,	rificate be executed ng physician and as the burial-transit	ledical E	d								
	rtifical ng phy as th	Medi	IF FEMALE:			<u>.</u>			T		
X Q Q	w requires that the death ceri been signed by the attendin should be detached for use	Physician/N	23c. 23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	Ideath 3	Ectopic pregnanc	ÿ			Date of del Month	ivery Day Year
	the a	ysici	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4 ☐ Pregnant at time of c 9 ☐ Unknown	leath 5L	Other (specify) _					
J.	that the		Part II. Other significant conditions contrib	outing to death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use c	ontribute to	the cause of death?
rds	quires n sign ald be	d by						1 🗆 Y	′es 2∐XNo	3 □ Pr	robably 4 🗌 Unknown
Kecords,	law rec as bee 2 shou	Completed						24a. Was a		b. Were au	utopsy findings available completion of cause of
	The ate h	Ĕ						perfor	med? 212 No	death? 1 ☐ Yes	_
VItal	nysician: The nis certificate director, pag	Be	25. Was case referred to medical examiner?			1044	26. Place of Dea	th (Check only o	ne)		
6		၉	1 Yes 2 No Hos 27. Manner of Death	ortal: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatie		4 LI Nursing H	ome 5 🔀 Resid			cify)
	ding h. After funer	ţ	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury	Wor	k? Yes 2 □ No	200. 200011201	1011 11.19 00.		
Division	Attending ir death. ector: After by the fune	ifica	2 Nooidoni	28e. Place of Injury - At he building, etc. (Specif	ו ome, farm, sti לע)	reet, factory, office		28f. Location (S City or Tow	Street and Nu	ımber or Ru	ural Route Number,
	tal or s afte al Dir	Certification:	4 I Hornicide					1			
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director. After this completely filled in by the funeral di	Medical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examiner	ian: To the best of my kno	wledge, deat ation and/or in	th occurred at the tinvestigation, in my	ime, date and place opinion, death occu	e, and due to the irred at the time,	cause(s) and date and pla	d manner a ce, and due	s stated. e to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number		29d. Date si	gned (Mont	th, Day, Year)
	->-0		Den Ba	11h 20		D00.	5457	9	0610	1121	Poo
2	7		30. Name and address of person who comp	1 1 4			100	11 0 1	(10	101.	lanham, Mp
U	,		Tlanetene By	32 Registrar's Signs	980		X11 PG	IT KON	70	121	annam,11D
	Sta Registi		31. Date filed (Month, Day, Year) JUN 0 4 2009	32. Registrar's Signa	backer						

DHMH 17 Rev 1/2001

The law requires that the death certificate be executed the attending physician ed for use as the burial -Box 68760, P.0. signed Records, should s certificate has b rector, page 2 sho To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi of Vital Director:

Approximate Interval Between Onset and Death Year Pregnant at time of death 5 Other (Specify 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>≦</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available autopsy performed? death? ✓ Yes 2 No 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) 8 examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 DOA 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Natural unk Pending Fd 6/4/09 Fd 1110 hts Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5000 Lydianna Ln. #425 Suitland, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be determined (Specify) residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 **OCME 2006**

PY

Sa

State Registrar

29b. Signature and title of certifie

Russell Alexander MD

ORIGINAL

and manner stated

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

W W 1918

June 5, 2009

OCME

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-04339 State of Maryland / Department of Health and Mental Hygiene Patrick Joseph Meckel Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day May 31, 2009 0950 hrs **Medical Examiner** Patrick Joseph Meckel 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Carroll New Windsor Rt. 407 s/o Bowersox Road 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Months Days Oct 02 1991 Country) MD Director 17 2 F 218-33-1411 TX M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10a. State 10b. County 1 Yes 2 XNo 23a or 28a-f show notified at once. Union Bridge Carroll permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10g. Citizen of What Country 10f, Zip Code 10e. Street and Number USA 21791 3535 Middleburg Road 14 Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married Yes 2 X No White If Yes, Give Year Yes 2X No specify: Widowed Divorced \$ 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done Decedent's Education (Specify only highest grade completed) leted during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) item 27 is marked other than traumatic event, the Medical Education 21215-0036 Student Compl 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Victoria Lynn Glaze Be Albert Joseph Meckel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3535 Middleburg Road Union Bridge, MD 21791 Albert Meckel/father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place) Cremation 3 Removal from State 1X Burial 2 Uniontown, MD 6/05/2009 St. Paul Cemetery Other Specify Donation 5 21. Sign were of Fun all Service Licensee 22 Name and Chapel, P.A. 21157 ank 412 Washington Road Westminster, MD Approximate Interval 23a. Fart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure List only one cause on each line Death **Medical** a. Multiple Injuries Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical ysician a UNPENDED AMENDED Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: ing phy: as the b Year Day 23h Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Pregnant at time of death Other (Specify, 5 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. Yes 2 No 3 Probably 4 🗸 Unknown ģ Completed Division of Vital Records, 24b. Were autopsy findings available 24a. Was an has been a prior to completion of cause of autopsy death? performed? r this certificate he 1 🗸 Yes 2 No ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Other, examiner? Residence 6 V Other: Scene Nursing Home 5 DOA Inpatient 2 ER/Outpatient 3 No 1 Yes 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Subject driver of vehicle involved in vehicular Certification May 31, 2009 0940 hrs Natural Yes 2 V No Pending I Director: 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be or Town, State) Rt. 407 S/O Bowersox Road, New Windsor, MD determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal

29d. Date signed (Month, Day, Year)

June 1, 2009

Division
To the Hospital or Attendiving the Hospital or Attendiving the Hospital Diversor.
To the Funeral Director:
completely filled in by the formation of the Hospital Director.

Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

29c. License number

O.C.M.E.

OCME

and manner stated

30. Name and address of person who completed dadse of death (Item 23a)

29b. Signature and title of certifier

Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician

/Medical

Director

Funeral

Completed by

Be

၉

Physician/Medical Examiner

Be Completed by

Medical Certification: To

Examiner

Funeral

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydjene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once.

Physician

/Medical Examiner

Baltimore, Maryland 21215-0036

State Registrar

E quoritiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): C. Due to (or as a consequence of): d.	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 □ No 3 □ Probably 4 □ Unknown
		24a. Was an autopsy performed? 1 □ Yes 2 No 1 □ Yes 2 □ No
25. Was case referred to medical examiner?		n (Check only one)
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Ho	me 5 Residence 6 Other (Specify)
27. Manner of D ath Natural 5 ☐ Pending 2 ☐ Accident investigati		28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		 Location (Street and Number or Rural Route Number, City or Town, State)
	Physician: To the best of my knowledge, death occurred at the time, date and place, aminer: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	
29b. Signature and title of certifier	29c. License number 0.4563	29d. Date signed (Month, Day, Year) 5/29/09
Arnuljo	130000	Hwy, Upper Marlboro, MD 20772
31. Date filed (Month, Day, Year)	2009 Sinus B. Janes	
	ORIGINAL	2442 - 42

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month May Day 29 2009 4:04 PM Margaret L. McDaniels 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours 579 46 0043 79 Dec 31, 1929 West Virginia Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ▼No Maryland Prince George's Fort Washington 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 9557 Fort Foote Road 20744 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: **Black** 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Human Resources Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ear1 James Lula Mae Wallace 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Currie (Daughter) 5204 Taft Road, Camp Springs, MD 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Crematory June 2, 2009 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 mon Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 ☐ 25. Was case referred to medical 26 Place of Death (Check anly one) Hospital: 1 Yes 2 No 1 ☐Inpatient 2 ☐ ER/Ou

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Examine

Funeral

Director

show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumetic event, the Machael Expression of the modified at once.

Baltimore, Maryland 21215-0036

burial-transit attending physician for use as the buria signed by the a icate has been sig ; page 2 should b certificate has

The law requires that the death certificate be exec

P.O. Box 68760

Division of Vital Records,

Hospitel or Attending

funeral director, After this within 24 hours after death. To the Funerel Director:

Physician/Medical 2 Completed Be Certification: To filled in by the Medical npletely

27. Manne eath

2 Accident

4 Homicide

(Check only one)

29b. Signature and title of certifier

3 Suicide

29a. Certifier

1 Natural

State Registrar

	20. I lace of Death (Oricon Drily Oric)								
utpatient	3 ☐ DOA	Other: 4 I Nursing H	lome	5 Residence	6 ☐ Other (Specify)				
Time of	28c.	Injury at	28d.	Describe how inju	ry occurred				

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

no completed cause of death (Item 23a) (Type, Print) 30. Name and address of person with

28a. Date of Injury (Month, Day, Year)

Rd Ste 300 Annapolis, MD 2140 900 32. Redistrar's Signature Year)

29c. License number

JUN 0 3 2009

5 Pending investigation

6 Could not be determined

28b.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

09-04511

Richard Benjamin Naylor, Jr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 19525

	1- For State Registrar		Sertificate	or Dea	าเก			eg. No.		
Physician/ edical Examine	Decedent's Name (First, Midd		AYLOR	JR.			2. Date of Dea Month June 6, 20	Day Y	ear	3. Time of Death 1358 hrs
	4a. Facility Name (if not instituted Prince George's Hosp			1 1	r, Town, or Lo	ocation of Death		4c. Count Prince	y of Death George's	5
Funeral Director	5. Social Security Number 216-88-6933	6. Sex 7. Age (In)	yrs. last birthday	, F	nder 1 Year nths Days	If Under 24Hrs Hours Min.	_	14 1969	Foreign	place (State or WASHINGTON
the Maryland a or 28a-f show any tified at once. Director	Usual Residence of Decedent 10a. State	CE GEORGE'S	City, Town or Lo	VER	Zip Code			I0g. Citizen of		10d. Inside City Limits 1 X Yes 2 No
or items 23. must be no	11. Mantal Status 1 X Never Married 2 N	VEN DRIVE # 203 12. Was Decedent Ever Armed Forces? 1	in U.S. 13.	If Yes, spe		anic Origin? (Sp. Mexican, Puerto			nite, etc.	an Indian, Black,
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner. Completed by 1		l or Dates: ecify only highest grade complete) College (1-4 or 5+)	16a. Dece durir	edent's Usung most of	ual Occupation working life. I	on (Give kind of to OO NOT use reti	ired)	16b. Kind of	ATE	dustry
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	RICHARD B. NA	YLOR SR.				8.Mother's Name VELMA (CARTER			
D Me m 27	19a. Informant's Name/Relation VELMA NAYLOR/		19b. Ma 191	ailing Addr 9 BEI	ess (Street LLE HA	and Number or VEN DRIV	Rural Route Nu VE # 20	3 LANDO	VER,M	D 20785
Baltimore, MD permit. Pages I and 2 sh Department of Health an Important: If item 27 is injury or other traumat	20a. Method of Disposition 1 Burial 2 X Crematic 4 Donation—5 Other S	on 3 Removal from State	20b. Place of Di crematory of RIVERDA	or other pla	ice)		Date 13/2009	20c. Location		own, State MARYLAND
Baltir permit. E Departme Importa injury o	21. St., ature of Fune at Service	e Licasee				of Facility J. VER ROA				
Physician Medical	failure. List only one caus	**************************************		iter the mo	de of dying, s	such as cardiac	or respiratory a	rrest, shock, or	heart	Approximate Interval Between Onset and Death
caminer	Immediate Cause (Final diseas or condition resulting in death)	Due to (or as a conseque		TOBCI	CIOCI	Carar	o va bear			
ed nsit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated		ence of):							
and and - transit		Due to (or as a conseque		P = 0	m <u>u <i>t l</i> '</u>	10 /00 mi	n			
760, cate be exe physician a he burial -	X UNPENDED	AMENDED Z3a,	2/,perM	E, go	92 0/4	29/09 1	L 			
box 68760, the death certificate be exert to the attending physician a ched for use as the burial - Dhysei i and Medical	IF FEMALE: 23b. Was decedent pregnant in past 12 months?	4 Pregnant at time	2	Fetal de		Ectopic pregr	nancy	23d. Dat Mont	e of delivery h C	Year Year
P.O. Box 68 s that the death certi gned by the attendin e detached for use a	Part II. Other significant cond	9 Unknown litions contributing to death but	t not resulting in	the under	ying cause gi	iven in Part I.				the cause of death?
cords, law requires has been sig							24a. Wa		b. Were au	topsy findings available completion of cause of
tal Recol	25 Was seen referred to modify	cal		_	26.Place	of Death (Chec		2 140		2 110
Vital hysician this cert I directo	examiner?	Da Committee Com	2 V ER/Outpa	atient 3	DOA	Other Nurs	ing Home 5	Residence	6 Other	:
on of Vital Rec anding Physician: The ath. rr: After this certificate he funeral director, page		28a. Date of Injury (Month, Day, Year)	28b. Tim	e of Injury	1	y at Work? 'es 2 No	28d. Describ	e how injury or	curred	
Division pital or Attendio ours after death. teral Director: /	3 Suícide 6 Co	vestigation 28e. Place of Injury termined (Specify)	- At home, farm	, street, fac	ctory, office b	uilding, etc.	28f. Location or Town		umber or Ru	ral Route Number, City
Di Di Within 24 hours a To the Funeral I	29a. Certifier	Physician: To the best of my kn	owledge, death ation and/or inve	occurred a	t the time, da	ate and place, ar , death occurred	nd due to the ca	ause(s) and ma te and place, a	nner as stat	ed. ne cause(s)
5 in	29b. Signature and title of certi	and manner stated.			29c. Licens			29d. Date June 8,		nth, Day, Year)
		on who completed cause of death tant Medical Examiner	h (Item 23a) 111 Penn S	Street B						
Star	11117				Similar City	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State Of Wally 16	•	rtificate of i			leg. No.	19526
			1. Decedent's Name (First, Middle, Last)		1		2. Date of Dear Month	th Day Year	3. Time of Death
	Physicia /Medic	al		NELS		P		28 2009	9:20 A M
	Examin	er	4a. Facility Name (If not institution, give street and number) Carroll Hospital Center		4b. City, Town, or Westmin	Location of Death		4c. County of Dea	ıtn
	Funeral Director			rs. last birthday) 88 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Jan. 24	9. Bir	rthplace (State or Foreign ountry) ryland
	put &		Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Lo	ocation				10d. Inside City Limits
	Maryla f sho	ro	Total State	Manchest					1 □Yes 2 X No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is "noted Examinating at ange.	Funeral Director	10e. Street and Number 3606 Schalk Road #1		10f. Zip Code 21102			10g. Citizen of What C United Sta	
	r deat	uner	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
9000	ours afte ral", or it Lexamin	Completed by Fi	1 ☐ Never Married 2 ☐ Married If Yes, Give Ye ar or Dates:		1 □Yes 2 No	Specify:			white
15-(in 72 h n "natu	plete	15. Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual Occup e kind of work done DO NOT use retired	during most of workii	ng	16b. Kind of Business	·
212	d with rgiene er thau	Com	Elementary/Secondary (0-12) College (1-4or 5+) 12	super	rvisor	<u></u>		tool Manu	facturer
Maryland 21215-0036	uld be file Mental Hy Irked oth	To Be (17. Father's Name (First, Middle, Last) George William Nelson, Sr.			18. Mother's Name Anna H. I	oella		
, Mar	and 2 sho satth and n 27 is ma er trauma		19a. Informant's Name/Relationship (Type. Print) Brenda N. Taylor — daughter	1121	Moonbow	Drive W	estmins	er, City or Town, State, ter, Maryl	and 21157
Baltimore,	Pages 1 annount of He ant: If iten		20a. Method of Disposition 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	b. Place of Dispo cemetery, cre carroll (osition (Name of matory or other plac Cremation		^{2at} 30, 009	20c. Location - City o	
Balti	permit. Departr Importa any Inju		21. Signature of Funeral Service Licensee Mo Mo		2. Name and Address 34 South		ine Fun et Ham	eral Home pstead, Ma	ryland 21074
			23a. Part 1. Enter the disease, or complications that caused the d shock, or heart failure. List only one cause on each line.	eath. Do not en	nter the mode of dyin	ng, such as cardiac o	or respiratory ar	rest,	Approximate Interval Between Onset and Death
-	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	KING	+				
ľ	Examiner		Due to (or as a con	sequence of):	15 de	emunt	G		
	p ±	iner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	Due to (or as a consequence of).					
	tificate be executed g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C Due to (or as a con	sequence of):					
68760,	e be e /sician e buria		d						
		Medical	IE EEMAI E-						
O. Box	The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pre 1 □ Live birth 2 □ II 4 □ Pregnant at time 9 □ Unknown	etal death 3	☐ Ectopic pregnand ☐ Other (specify) _	су		23d, Date of d Month	lelivery Day Year
ď.	that the	y Ph	Part II. Other significant conditions contributing to death but not	resulting in the u	underlying cause giv	ven in Part I.	23e. Did to	obacco use contribute	to the cause of death?
rds	equires en sign	ed b	Atriol Fibrillati	00			1 🗆)	Yes 2 No 3□	Probably 4 Unknown
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached.	Completed by					24a. Was autop perfo 1 □Yes	osy prior t rmed? death	
Vita	Iclan: sertific ector, I	Be (25. Was case referred to medical examiner?		Cut	26. Place of Death			
of	Physic r this caracteristics	- 1 1	27. Manner of Death 28a. Date of Injury	28b. Time	of 28c. Inju	ry at		dence 6 Other (S) how injury occurred	pecify)
ion	ndlng ath. r: Afte e fune	ation	1 □ Natural 5 □ Pending (Month, Day, Yea 2 Accident investigation	7) 8 Injury	. Wo	rk?]Yes 2.☑No	Choke	ed on fo	٧٥
Divis	al or Atte after dea Directo	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury 2 building, etc. (Set Not Not Not Not Not Not Not Not Not No	At home, farm, st	treet, factory, office		28f. Location (3 City or Tox West M: M	Street and Number or wn, State) 2005 (4(MD 3	Rural Boute Number
	Hospita 24 hours Funera etely fille	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examiner and manner stated.	knowledge, dea	ath occurred at the t investigation, in my	ime, date and place,	and due to the	cause(s) and manner	as stated. ue to the cause(s)
		Me	29b. Signature and title of certifier Acompaginary (MD//)	Apri	29c. Licen	se number P00°	1934	29d. Date signed (Mo	
	WILL		30. Name and address of person who completed cause of death M. PANSURIYA 349			west.	minste	of mi)	11157
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's S	h	backet				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 5/29/09 9:20 Josephine Nance a 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince George Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Days Months 1 □ M 2 🖫 F 95 3/24/1914 South Carolinia 247-34-4467 Usual Residence of Decedent 10d Inside City Limits 10b. County 10c. City, Town or Location 10a, State ¥☐Yes 2☐No Maryland Prince George Brandywine 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 15805 Brandywine Road <u>USA</u> 20613 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes X ☐ No Specify: Black 3X Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Beautician Entrepreneur 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elijah Briggs Cora Gordon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Anthony McKinley/Nephew 15805 Brandywine Rd, Brandywine MD 20613 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harmony Mem. 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 6/6/2009 Landover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Funeral Home pA, Aquasco MD 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Atrial disease or condition resulting in death) Due to (or as a consequence of): ardior Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 ☐ Ectopic pregnancy Year Month Day 5 ☐ Other (specify) 9 Unknown II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 25

Physician /Medical Examine

Department of Health ar Important: If item 27 is any injury or other trau

Physician

Examiner

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Modical Examination to the modified at

Pages 1 and 2 should be filed within 72 hours after of the tot of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or ite

Saltimore, Maryland 21215-0036

/Medical

Director

Funeral

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Completed

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burial-tran physician at the burial ate has bade 2 s certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

requires that the death certificate be executed

Box 68760.

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11-1-	EMALE:
23h.	Was decedent pregnant
	in the past 12 months?

25. Was case referred to medical	26. Place of Death (Check only one									
examiner? 1 ☐ Yes 2 ██	Hospital: 1 phpatient 2 [☐ ER/Outpatient 3 ☐	DOA Other: 4 I Nursing H	ome 5 ☐ Residence 6 ☐ Other (Speci						
27. Manner of Death 1 □ Matural 5 □ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred						

1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) sunattire Clinton, mo 20 735 32. Registrar's Signature 31. Date filed (Month, Day, Year) JUN 0 3 2009

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	-	For State Registrar	State of Marylan		tificate of L				009	1952
Physicia /Medic	an	1. Decedent's Name (First, Middle, Bettv		eifle			2. Date of Dea Month May 30	Day	Year	3. Time of Death 5:30 a M
Examine Funeral	er	4a. Facility Name (If not institution, 3427 Glenn Drive 5. Social Security Number 227–28–9667	give street and number) 3. Sex 1 □ M 2 🏋 81	last birthday) Yrs.	4b. City, Town, or Sur If Under 1 Year Months Days	itland If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month Day Sept 14)	I I	9. Birtho	George's place (State or Foreig ginia
7.2 hours arer dearn with the living and natural", or items 23a or 28a-f show addical Examiner must be notified at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince (10c. Cit	y, Town or Loc Suitland	cation					0d. Inside City Limit
23a or 28a ust be noti	Funeral Director	10e. Street and Number 3427 Glenn Drive		1-	10f. Zip Code 20746			10g. Citizen o		
ral", or items	py	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 🖾 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 2 2 3 No If Yes, Give Year or Dates:		Vas Decedent of Hi fYes, specify Cuba I∐Yes 2⊠No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	Spec	ace - Americ lack, White, hify:	
Department of Health and Mental Hygiene. Important: or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+)	16a. Deced (Give life. L Cash:	dent's Usual Occupa kind of work done o DO NOT use retired Ler	ation furing most of work)	ing	16b. Kind of Giant		dustry
and Mental Hyg s marked other umatic event,	To Be C	17. Father's Name (First, Middle, L. Elmer Vance	е			18. Mother's Nam	Patterson	1		
f Health and Item 27 is m other traum		19a. Informant's Name/Relationshi Vance Cameron / Soi 20a. Method of Disposition	n	3427	g Address (Street a Glenn Drive sition (Name of natory or other place	e Suitland,	Maryland		5	
Department of Important: If its any injury or o once.		1 ☐ Burial 2 XXCremation 3 4 ☐ Donation 5 ☐ Other (Spot) 21. Signature of Funeral Service Li	ecify) Kal	las Crem		ss of Facility G	orge P. K		neral H	ome P.A.
Medical street burial-transit	edical Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to minieurate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	warica off).	ve 4e ry ai	out I	ailu Disea	se		Interval Between Onset and Death
attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♣ No 9 □ Unknown	23c. If yes, outcome of pregni 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of o	al death 3	☐ Ectopic pregnancy ☐ Other (specify)	у		1	Date of delive Month	very Day Year
s been signed by the should be detached	ρ	Part II. Other significant condition	ns contributing to death but not res	ulting in the u	nderlying cause give	en in Part I.		obacco use c Yes 2 □ No		the cause of death
this certificate has be al director, page 2 sho	Completed	25. Was case referred to medical				26 Place of Don		osy rmed? 2ENo	b. Were aut prior to co death? 1 ☐ Yes	opsy findings availa ompletion of cause 2 No
bath. T: After this cer he funeral direct	Certification: To Be	examiner? Hospital: Other								
within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral.		3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could nedetermin 29a. Certifier XE Certifying	building, etc. (Special Physician: To the best of my known	owledge, deat	h occurred at the tir	me, date and place	City or To	wn, State)	I manner as	stated.
within 24 r To the Fu completely	Medical	one) 29h Signature and title of certifier	xaminer: On the basis of examine and manner stated.	ation and/or ir	29c. Licens		irrea at the time,	29d. Date sig		
3		30. Name and address of pe son v Crystal P. Yeldel		Way Suit		land 2074	6			

DHMH 17 Rev 1/2001

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		1 - State Registrar Amend #7/8	per infor. 6	5/9/0 9 9	AGHC E	T GMOT L	Jeath ————————————————————————————————————	2. Date of Dea	leg. No.		3. Time of D)eath		
Physici /Medic		Decedent's Name (First, Middle, La MILDRED	T. REED		1			Month MAY	30 Day	2009 ^{Year}	0005	М		
Examin	er	4a. Facility Name (If not institution, giv PRINCE GEROGE'S		HOSPITAL CHEVERLY						PRINCE GERO				
Funeral Director			66 TIS.							8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) WASHINGTON, DC 3/3/1942				
aryland show	ž	10a. State 10b. County		City, Town or Lo		OURG		0/0/	10d. Inside City L 1∐Yes 2[
th the M or 28a-f	Funeral Director	MD PRINCE (10e. Street and Number		EORGE'S CAPITOL HEIGHTS 10f. Zip Code						10g. Citizen of What Country?				
ath wi	la	4114 BYERS STREI				2074		-14 - No No.	USA	A. Race - Americ	an Indian			
n 72 hours after death with the Maryland n "natural", or items 23a or 28a-f show tedical Examinar must be netthed at	ρ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Ever in Armed Forces? 1	i U.S. 13.	Was Dece If Yes, sp 1 □Yes		spanic Origin? (S n, Mexican, Puert Specify:	pecity Yes of No- o Rican, etc.)		Black, White,				
	Completed	15. Decedent's E (Specify only highest gra	de completed)	a kind of w	dent's Usual Occupation kind of work done during most of working DO NOT use retired)			16b. Kind of Business/Industry						
I within jiene.	E O	Elementary/Secondary (0-12) 12th	College (1-4or 5+)		PROGE	RAM A	NALYST		G	OVERNME	NT			
be file tal Hy d oth	To Be C	17. Father's Name (First, Middle, Last EDGAR R. THOMPSON						or's Name (First, Middle, Maiden Surname) ORENCE D. THOMPSON						
Te, Mar yiaring 1 and 2 should be file 1 Health and Mental Hy 1 tem 27 is marked oth other traumatic event		19a. Informant's Name/Relationship (CARLTON THOMPSO)		19b. Mail 800	ing Addres	SS (Street)	and Number or Ru IELD COU	ural Route Numbe	er, City or MA	Town, State, Zip RYLAND	0 Code) 20715			
Definition (e), permit. Pages 1 ar Department of Hea mportant; If item any Injury or other once.		20a. Method of Disposition	20	b. Place of Disp cemetery, cre	osition (Na	ame of other plac	e) !	Date	20c. Loc	ation - City or To	wn, State			
Page nent c int; if		1 ☐ Burjal 2 ☐ Oremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Remedal from State	/			ORY : 6/6			RDALE, MA				
permit. Pages 1 and 2 Department of Health s Important: If item 27 is any Injury or other tra <u>once.</u>		22. Name and Address of Facility J. B. JENKINS 7474 LANDOVER ROAD LANDOVER, MAR												
Physician		23a. Part 1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition	pliestions that caused the done cause on each line.	eath. Do not en	nter the mo	ode of dyir	ig, such as cardia	c or respiratory a	rrest,		Approximate Interval Betw Onset and D	eath		
/Medical Examiner		resulting in death)	Due to for as a cons	sequence of):							2 wks	,		
be executed ician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	5 tag	c 0	Ren	Il di.	sea se			wlyv.			
	<u>a</u>	d												
S di ce 🗲	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	□ Ectopic □ Other (у		2	3d. Date of deliv		/ear		
v requires that the d been signed by the should be detached	þ	Part II. Other significant conditions Sarcon Jon	cause giv	en in Part I.	23e. Did tobacco use contribute to the cause of 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐									
e lav	Completed					-		24a. Was autoj perfo 1 □ Yes	osy rmed?	24b. Were aut prior to c death? 1 □ Yes	ompletion of ca	availab ause o		
sician: The certificate rector, pag	Be C	25. Was case referred to medical examiner?					26. Place of De	ath (Check only o						
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Vitending Pr death. ctor: After th y the funeral	ation:	27. Manner of Death 1	(Month, Day, Yea	28a. Date of Injury (Month, Day, Year) 28b. Time of lnjury 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No				28d. Describe how injury occurred				-		
tal or Attencts after the Director:	Certification: To	3 ☐ Suicide 6 ☐ Could not to determined	building, etc. (Sp	есіту)				City or To	wn, State,			ber,		
To the Hospital or / within 24 hours after To the Funeral Dire completely filled in b	Medical (29a. Certifier 1	hysician: To the best of my miner: On the basis of exar and manner stated.	knowledge, de mination and/or	ath occurre investigati	ed at the to	me, date and plac opinion, death occ	ce, and due to the curred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s	;)		
To th within To th	Me	29b. Signature and title of certifier	el mo		2	9c. Licens	se number 05821	3	29d. Dat	e signed (Month	, Day, Year)			
0.8		29b. Signature and title of certifier Annual Jun 30. Name and address of person who FARHAD JAM	completed cause of death ((Item 23a) (Type	e, Print)	enwa	y ctr 2	Dr. Gre	eule.	elt m	0207	70		
St: Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 2;36pm **Physician** tokes 04 TUNE 2009 Danie /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimose Hospital Housor If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 7.66.3342 1 M 2 □ F MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director D. 10g. Citizen of What Country? 10e. Street and Number ō 2122 617 NA JILUS A 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? or items 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify JANTE \$ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "na any Injury or other traumatic event and once." Elementary/Secondary (0-12) College (1-4or 5+) MANUFACTURING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HENRY L. STOKES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1037 Run Greek DR. C. ROWNSYILL 10.2032 DAVID STOKES JR. 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State IENHAVENMENDRIAL PREVI 6-8-09 GENBLANIE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DAUMEATY FUNERAL HOME 21. Signature of Funeral Service Lice MO1452 ASADENA, 2601 MOUNTAIN RD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final week near **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to foras a consequence of: netastatu adenocarcinono To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year In the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached it 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 3 Probably 4 Unknown Kidno. 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28c. Injury at Work? Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours a er death, To the Funeral Director: A completely filled in by the fu investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tittle of certifier

State

DHMH 17 Rev 1/2001

Registrar JUN 1 7 2009

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harbor Hospital, 3001

32. Registrar's Signature

RES -001

South Hanover Street, Baltimore, MD 21225

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	•	For State Registrar	State of Maryland			nt of Hea te of De			giene Reg. Nacy ()	0.0	10501
Physicia /Medic		Decedent's Name (First, Middle, La GEORGE	STEWART					2. Date of Dea Month MAY		00%	2:15 A M
Examin	135	4a. Facility Name (If not institution, given MAGNOLIA NURSIN			4b. City, Town, or Location of Death LANHAM				4c. Count PRIN		ROGE'S
Funeral Director		210-30-3030	Sex 7. Age (In yrs. las 103	t birthday) Yrs.	If Unde Months		Under 24 Hrs. ours Min.	8. Date of Birth (Month, Day JULY 1	h y, Year) 4 1905		place (State or Foreign htry) LAND
faryland	or	Usual Residence of Decedent 10a. State 10b. County		Town or Lo						1	10d. Inside City Limits 1 X Yes 2 □ No
death with the Maryland ms 23a or 28a-f show irrust be notified at	Director	10e. Streef and Number		10f. Zip Code				10g. Citizen of What Country? USA			ntry?
5 £ 5	by Funerai	9300 TUCKERMAN 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	STREET 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:				nic Origin? (Spelexican, Puerto	ecify Yes or No- Rican, etc.)	- 14. Ra Bla	ice - Americack, White,	etc.
within 72 ho ene. then "natur	Completed t	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 5th		(Give	kind of w	ual Occupation ork done during use retired)	n g most of work	ing	16b. Kind of E		dustry
id be filed ental Hygic ked other ic event,	To Be C	17. Father's Name (First, Middle, Las PATRICK STEWAR'				18.	Mother's Name	e (First, Middle,	Maiden Suma ENRY	тө)	
re, Maryiand s 1 and 2 should be f Health and Mental F Item 27 is marked of other traumatic eve		19a. Informant's Name/Relationship BETTY GROSS/DAU						LANHAM,			706
SAIKIMOFE, IN bermit. Pages 1 and 2 Department of Health mportent: If item 27 I nny Injury or other tra		20a. Method of Disposition 1	Removal from State	ce of Disponetery, crer	natory or	other place)	1	Date / 2009	20c. Location	-	own, State
DESILIMON permit. Pages: Department of F Importent: If its eny Injury or of			nsee		2. Name a	nd Address of	Facility J	. B. JE	NKINS F	UNERA	L HOME
Physician /Medical Examiner physician and physician and physician and the prinal-transit	Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseque C. Due to (or as a conseque d.	nce of):	THR	IVE					Onset and Death 2 MONTHS UNICHOWN
O. BOX on the death certification the attending part and for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 mopMfs? 1 ☐ Yes 2 ☑ Mo 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ Mor							ate of deliving	e of delivery th Day Year	
uires that the signed by		Part II. Other significant conditions HYPERTENSIO		Did tobacco use contribute to the cause of deat 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unk							
UNISION OF VITAL RECORDS, I or Attending Physician: The law requires that after death. Director: After this certificate has been signed in by the funeral director, page 2 should be early the funeral director.		BENIGN PROSTAT	ic Hypertro	HYPGRIROPHY				24a. Was auto perio 1 Yes	prior to completion of cause of death?		ompletion of cause of
OT VITAL Physician: The this certificate al director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 E	R/Outpatier	nt 3 🗆 🖸	Other		th (Check only only one 5 Resi		ther (Spec	ıfy)
VISION OF VITAI Attending Physician: r death. ector: After this certifica by the funeral director, p	Certification:	27. Manner of Death 1 Anatural 2 Accident investigations 3 Suicide 6 Could not						28d. Describe how injury occurred			
DIVISION SITE OF Attentions after death real Director:	Certifi	4 Homicide determine	building, etc. (Specify)	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					wn, State)		ral Route Number,
To the Hospitel o within 24 hours at To the Funeral D completely filled in	edical	29a. Certifier 1 Certifying F (Check only one) 1 Medical Ext	Physician: To the best of my know aminer: On the basis of examinate and manner stated.	ledge, deat on and/or in	h occurre vestigation	d at the time, on, in my opini	date and place, on, death occur	and due to the red at the time,	date and place	e, and due	to the cause(s)
To the within 2 To the comple	W	29b. Signature and title of certifier				ec. License nu			29d. Date sign	1	n, Day, Year)
13			525 GREENWAY CE	NTER		E # 105	GREEN	BELT,MA	RYLAND	2 0 /70)
Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signatu								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day SMITH MELISSA J. 2009 5:45 JUNE 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) PRINCE GEORGE'S CLINTON SOUTHERN MARYLAND HOSPITAL Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Days Months Hours Min. 1 □ M 2 🔽 F 244-33-2636 41 Yrs. WILSON, 26 1968 N.C. FEB. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 X Yes 2 No CAPITOL HEIGHTS PRINCE GEORGE'S 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 1004 CLORIS AVENUE 20743 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian. 11. Marital Status 1 □Yes 2 □No If Yes, Give Year or Dates: 1 ☐Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BILLING CLERK PRIVATE 12TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JO ANN HINTON CLYDE SMITH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2409 HORTON BLVD #3 WILSON, NORTH CAROLINA 27893 JO ANN SMITH/MOTHER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/4/2009 RIVERDALE, MARYLAND RIVERDALE CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Due to (or as a conseque e of): Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last a consequence of) Pen Due to (or as a consequence of): If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part. 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 No 2-No 1 ☐ Yes 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No 1 Tes 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA

Physician) /Medical Examiner executed

Physician

/Medical

Examiner

Funeral

Director

show

Director

Funeral

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Completed

Be

MD

r than "natural", or items 23a or 28a-f shours Medical Examiner must be notified at

within 72 hours after death with

permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other traumation.

Maryland 21215-0036

Baltimore,

P.O. Box 68760

Division of Vital Records.

The law requires that the death certificate be

and burial-tran attending physician the use ō the detached signed by has

Examiner Physician/Medical \$ Completed Be Certification: To

certificate this completely filled in by the funeral After i within 24 hours after death. To the Funeral Director: A

Hospital or Attending Physician:

State Registrar

Medical

23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28c. Injury at Work? (Month, Day, Year) 1 □Yes 2 □No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certific

5 Pending investigation

6 ☐ Could not be

determined

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 32. Registrar's Signatu

JUN 0 4 2009

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

28a. Date of Injury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Year 12:12 P M JMMeth 1, 2009 **Physician** Anetha Perry Smith /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Ft. Washington Ft. Washington Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Feb. 8, 1950 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Months Hours Min 1 □ M 2 🛱 F North Carolina 577-68-6285 59 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 ☐ Yes 2 No a or 28a-f sh Director Maryland Prince George's Ft. Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with IISA 711 Gleneagles Drive 20744 23a "natural", or items 23edical Examiner must Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 □Never Married 2 □ Married Black 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of State Elementary/Secondary (0-12) College (1-4or 5+) Diplomatic Security 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wilkins Wade Perry Dorothy မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Vondell Smith - Son 711 Gleneagles Dr., Ft. Washington, MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Kalas Crematory June 3, 2009 Edgewater, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur unerabService Licensee 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 11./10/2 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STAge Physician END /Medical Due to (or as a contequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. Examiner law requires that the death certificate be executed physician and is the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p as IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown signed by t Id be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 4 Minknown 1 ☐ Yes 2 No 3 Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an cate has I autopsy performer certificate 1□ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3□ DOA P After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After the bletely filled in by the funeral 28c. Injury at Work? Certification: 1 Natural 2 ☐ Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only within 24 one 29c. License number 29d. Date signed (Month, Day, Year) 29b, Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Samuel J. Kleiman 11711 Livingston Road Ft. Washington, Maryland 20744 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 4 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2009 6:40 A M Sorrells June 2, Susan Lorraine 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery 25 Beauvoir Court Derwood Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday Date of Birth (Month, Day, Months Days 1 ☐ M 2 💢 F Virginia 200-52-4553 Nov 23, 1960 48 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2X No Montgomery Derwood 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20855 25 Beauvoir Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2X No Specify Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Kathleen Francis Smith Nelson Richard Downend 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Markus S. Sorrells/husband 25 Beauvoir Ct. Derwood, MD 20855 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State W. Arundel Crematory 06/03/09 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 12 months Colorectal Cancer Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe periormedi/ 1 □Yes 2 ☑No 1 ☐Yes 2 ☐No 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

Examiner

10a. State

Director MD

Funeral

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Completed

Be

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Funeral

Director

show

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death with

72 hours after

Maryland 21215-0036

Baltimore.

7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the "violical Examinar inust by Lodiffied at

Hygiene. filed within

permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien. Important: If item 27 is marked other tha any Injury or other traumath.

/Medical

and burial-tran attending physician the as nse for ned by the detached t signed I peen has certificate

The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

Examiner Physician/Medical ğ Completed To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 2 Certification:

اسی State Registrar 25. Was case referred to medical examiner? 2**X**] No 1 ☐ Yes 27. Manner of Death 1 X Natural

29a. Certifier

(Check only one)

29b. Signature and

Medical

5 ☐ Pending investigation 2 Accident 6 □Could not be 3 Suicide 4 Homicide

determined

28a. Date of Injury (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

ms/pls

and manner stated

D67421

29c. License number

29d. Date signed (Month, Day, Year) June 2, 2009

ddress of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

John Hays, 10 Center Drive Bldg. 10 Rm 12N226 Bethesda, MD 20892 M.D.

egistrar's Signatur

1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month Mary Cornelia Sparks 8:05 AM 2009 une 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Salisburg Rehabilitationa Nursing Ctr.
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Wicomico Year If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Days Hours Months 577-28-7606 88 03/13/1921 Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 1 Yes 2 No Salisbury Wicomico Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21804 USA 108 Eastern Ave. 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 😿 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify. Specify: white 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) housewife domestic 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Alice Thomas N.J. Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1911 Kipling Dr., Salisbury, MD 21801 19a. Informant's Name/Relationship (Type. Print)
Susan E. Martin/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 6/3/09 Salisbury Crematory Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Holloway Funeral Home Professional Association 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) year Liter Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 - Ectopic pregnancy Month Day 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 1 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗆 No 1 ☐ Yes 2 No 1 ☐Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 **1 H**o 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 [과Natural 5 Pending investigation

Examiner Division of Vital Records, P.O. Box 68760

the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans attending physician for use as the buria signed by the a t be detached f after death.

Director: After this certificate has been s
I in by the funeral director, page 2 should

Physician

/Medical

Examiner

Director

Funeral

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Be Completed

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Examiner

Physician/Medical

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Be Completed

Certification: To

Medical

2 Accident

3 Suicide

29a. Certifier

4 Homicide

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Midical Expriner must be notified at once.

Physician

/Medical

Baltimore, Maryland 21215-0036

Bark

To the Hospital or within 24 hours aft To the Funeral Di completely filled in

State Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 20

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 □Could not be

Robins, William H 200 JUN () 3 32 Registrar's Signature

Clinewa

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

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	r 28a-f	Funeral Director	MD 10e. Street and Numb	Allegany	y	Fr	ostbu	10f. Zip Code	10	10g. Citizen of What Country?			
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350	be flied within 72 hours after death with the Maryland Hylgiene. All Hylgiene. And other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fune	11. Marital Status 1 □ Never Married 2 □ Married 3 ★ Widowed 4 □ Divorced 12. Was Decedent Armed Forces? 1 □ Yes 2 ★ If Yes, Give Year or Dates:		? If Yes, specify C		was Decedent of F If Yes, specify Cub: 1 ☐ Yes 2 No	Ispanic Ongin? (S) an, Mexican, Puert Specify:	pecity Yes of No- o Rican, etc.)	Black, W			
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	and 2 sealth ar n 27 is ier trau		Bonnie Jac	ckson	Daughter		30 M	cCullob S			21532	, ., .,	
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egistrar edent's Name (First, Middle, Last) Gernard Gernard Golf Crestwood Ial Security Number 6. Second 15 -24-2667 Residence of Decedent 10b. County Yland Prince treet and Number 2706 Crestwood arital Status Never Married 2 Married Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grad mentary/Secondary (0-12) 12 Informant's Name/Relationship (T) Immela Turner/ Method of Disposition Wignature of Tree 1 Specify ignature of Tree 1 Specify only highest grad 1 Specify only high	Ave. S Ave. S	Turr Ity, Town or Loc randyv J.S. 13. V 44 6 16a. Decer Give Give Life. L Entre Turr 19b. Mailir 1270 6 Place of Dispo cemetery, crer Natio	4b. City, Town, c Brandy If Under 1 Year Months Days cation vine 10f. Zip Code 2061 Nas Decedent of It 1'Yes, specify Cub Id Yes 2 Mo John's Usual Occur kind of work done 20 NOT use retire preneu: ng Address (Stree 6 Cresty sition (Name of matory or other pla	Wine If Under 24 Hrs. Hours Min. 3 Hispanic Origin? (San, Mexican, Puer Specify: pation during most of word) 18. Mother's Nat Eva t and Number or R	2. Date of Deamonth 5 - 28 8. Date of Birt (Month, Da) 1 2 / 1 1 Specify Yes or Noto Rican, etc.)	Day 2009 4c. County of Princ (Year) / 1924 10g. Citizen of W USA 14. Race Specify 16b. Kind of Bu B. Turn Renta Maiden Surnam Der, City or Town,	9. Birthplace (State or Fore Country) Tennessee 10d. Inside City Lim Yes 2 1 What Country? e - American Indian, sk, White, etc. Black Usiness/Industry er Bus 1 100 State, Zip Code) ne MD 20613		
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entially list conditions, , leading to immediate a. Enter Underlying a (Liease or if jury nitiated events ing in death) Last	Due to (or as a consection) Due to (or as a consection) Due to (or as a consection)	quence of):		bV9Jah		<i>WHE</i>	y ban		
MALE: Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy gnant at time of death 5 ☐ Other (specify)					23d. Date of delivery Month Day Year		
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las case referred to medical				26. Place of De	auto perfo 1 □ Yes	psy ormed? 2 10 0	Were autopsy findings avail- prior to completion of cause death? 1 ☐ Yes 2 ☐ No		
xaminer?	Hospital: 1 ☐ Inpatient 2 [☐ ER/Outpatie	nt 3 DOA	ther: 4 🗆 Nursing	Home 5 Res	idence 6 Oth	her (Specify)		
anner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time o Injury	of 28c. Inju	ury at ork?	28d. Describe	how injury occur	rred		
Accident investigation					28f. Location (Street and Number or Rural Route Number City or Town, State)				
(Check only 2 Medical xam	iner: On the basis of exami	nowledge, deat	th occurred at the	time, date and pla	ce, and due to the curred at the time	e cause(s) and m , date and place,	nanner as stated. , and due to the cause(s)		
one)	and manner stated.						d (Month, Day, Year)		
olignaturo and the often tiller				1 / 10/			6 1.00		
	as case referred to medical aminer? Yes 2 140 anner of Death latural suicide Homicide Suicide Homicide Certifier (Check only one)	Cas case referred to medical aminer? Accident Suicide Homicide Ho	As case referred to medical aminer? Hospital: 1 Inpatient 2 ER/Outpatie	As case referred to medical aminer? As case referred to medical aminer? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA DOA	As case referred to medical aminer? Hospital: 1 Inpatient 2 ER/Outpatient 3 DCA Other: 4 Nursing Injury M 1 Yes 2 No Suicide Homicide Getermined Suicide Homicide Getermined Suicide Getermined Research Suicide Getermined Ceptifier (Check only one) Certifier (Check only one) Other: 4 Nursing 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 1 Yes 2 No 26c. Injury at Work? Action 1 Yes 2 No 26c. Place of Injury - At home, farm, street, factory, office	Comparison Com	Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use conditions contributing to death but not resulting in the underlying cause given in Part I. 24e. Was an autopsy performed? 1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 No 24b. Describe how injury occurs (Month, Day, Year) 28b. Time of Injury Mork? 28c. Injury at Work? 28d. Describe how injury occurs (Month, Day, Year) 28d. Describe how injury occurs (Month, Day, Year) 28d. Describe how injury occurs (Month, Day, Year) 28d. Describe how injury occurs (Suicide Good of the determined 28d. Describe how injury occurs (Suicide Good of the determined 28d. Describe how injury occurs (Suicide 28d. D		

DHMH 17 Rev 1/2001

09-04322 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene John Vansickler 1. For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2 Date of Death Physician/ Month Day May 30, 2009 John S. Van Sickler Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director April 21,1958 016-46-7979 1 XM 2 F 51 Yrs Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 28a-f show MDCharles La Plata other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once. Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 10695 Prince Charles Drive 20646 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc Armed Forces? Never Married 2 Married If Yes, Give Yeer Specify. Yes 2 X No specify: 4 X Divorced Widowed is marked other than "natural", Ś 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Fiber Optics Communications 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) event, Be Edward P. Van Sickler, Jr. Virginia Pla 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Important: If item 27 injury or other trauma Edward Van Sickler, III/Brother 150 Deerhaven Rd. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place)
Brinsfield-Echols Crem. Burial 2 X Cremation 3 Removal from State Donation 5 Other Specify. 21. Signature of Funeral Service Licenses M01458 **Physician** failure. List only one cause on each line /Medical a. Multiple Injuries Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit sician/Medical icate has been signed by the attending physician a page 2 should be detached for use as the burial -AMENDED UNPENDED Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? Live birth Fetal death 3 Ectopic pregnancy Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 된 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Completed 24a. Was an certificate has been autopsy performed? ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: Other₄ Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 After this 1 V Yes 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work 27. Manner of Death May 30, 2009 Natural Yes 2 V No

Weare, New Hampshire 20c. Location - City or Town, State 6/2/2009 Charlotte Hall,MD ²²ANCEHART CHOUS FUNERAL HOME, P.A. 211 St. Mary's Ave. La Plata, MD Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Death 23d Date of delivery Month Year 23e. Did tobacco use contribute to the cause of death? Yes 2 V No 3 Probably 4 24b. Were autopsy findings available prior to completion of cause of death? 1 🗸 Yes To the Hospital or Attending Physician: Division of Vital Residence 6 28d. Describe how injury occurred Certification: with auto Motorcyclist collided Pending within 24 hours after death To the Funeral Director: the 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) Rt 2 and Rt 665, Annapolis, MD (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. May 31, 2009 ente 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Margarita Korell MD. 31. Date filed (Month) Day 0003 2009 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001 **ORIGINAL** OCME **OCMF 2006**

1604 hrs

Country Virginia

White

10d. Inside City Limits

Yes 2 No

oreign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Van Dercook 11:15 AM Louise **Physician** Doris 2009 06 01 /Medical 4c. County of Death, 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HICANICA SALISHUNS ROGIENAL MIDICAL TENINSULA If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 5. Social Security Number Min. **Funeral** Months Days 1 □ M 2 🖫 F 87 08/27/1921 Washington, DC 578-18-7723 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Widtal Evan her must be notified at once. 10a. State 1 ☐Yes 2 No Salisbury Directo Maryland Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21801 9288 Hickory Mill Road Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 ▼ Married white 1 ☐ Yes 2 【No Baltimore, Maryland 21215-0036 Specify: Snecify: 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) domestic homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Earline A. Wilkerson Edgar Warner ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12209 Collins Rd., Bishopville, MD 21813 19a. Informant's Name/Relationship (Type. Print) Barry VanDercook/son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 6/3/09 Salisbury, MD Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Holloway Funeral Home Professional Association Signature of Fungral Service Licen Hel 501 Snow Hill Rd., Salisbury, MD 21804 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Approximate Interval Between Onset and Death CARDIOVASOULAR Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Physician/Medical Examiner spital or Attending Physician: The law requires that the death certificate be executed ours after death. In the control of the resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 D No 5 Other (specify) 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performe 1 □ Yes 2 12 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 NO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 28d Describe how injury occurred 27. Mann of Death 28b. Time of 28c. Injury at Work? 1 ✓ Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital o within 24 hours aff To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifie Medical

State Registrar (Check only one)

31. Date filed (Month

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

EASTERIN SINCE DA, SALISBURY MY 21804

and manner stated.

who completed cause of death (Item 23a) (Type, Print)

09-04610 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Robert Alexander Wenzing State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Medical Examiner Month June 10, 2009 ROBERT ALEXANDER WENZING 0618 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 207 Leslie Avenue Nottingham **Baltimore County** 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Director 214-80-8244 Months Days Hours Maryland 36 Sept. 7, 1972 1XM 2 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Yes 2 X No Maryland Baltimore items 23a or 28a-f shoust be notified at once. Baltimore County hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 207 Leslie Avenue 21236 USA Funeral 11. Mantal Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces' Never Married 2 Married White, etc. Yes 3 Widowed 4 X XDivorced If Yes, Give Yeer Yes 2 X XNo specify: White Specify: ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 hou.
Pepartment of Health and Mental Hygiene.
uportant: If item 27 is marked and ury or other transment. Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) North American College (1-4 or 5+) GED Trade School N/A Student 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Preston Warren Wenzing Marcell Jacinta Frazier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcell Jacinta Foxwell (Mother) 207 Leslie Avenue Baltimore, Md. 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, Date 1 Burial 2 X Cremation 3 Removal from State crematory or other place) Metro Crematory 6-11-2009 Baltimore, Md. Donation 5 Other Specify: Signature of Funeral Şej⊽lçe Licensee Name and Address of Facility al Home 7401 Belair Rd. Baltimore, Md. 21236 Physician 23a. Part I. Enter the makes, or complications that caused the ath Da not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line. Between Onset and /Medical Mixed drug (morphine) & Alcohol intoxication Examiner Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Box 68760, e death certificate be execut sician/Medical 23a,27,28a-f,perME, g893 7/23/09 TT attending physician or use as the burial -X UNPENDED AMENDED IE EEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day past 12 months? 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Phy requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 23e. Did tobacco use contribute to the cause of death? þ ۰ Completed Records, 24a. Was an autopsy performed' death? Yes 2 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner?

Division of Vital To the Hospital or Attending death. Director: hours after the Funeral

1 Yes 2 No 3 Probably 4 V Unknown 24b. Were autopsy findings available prior to completion of cause of No Other 4 Inpatient 2 1 Yes ER/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene No 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural Pending Yes 2 X No Fd 6/10/09 Fd 0610 hr 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City or Town, State) 207 Leslie Ave Nottingham, MD 3 6 X Could not be Suicide determined (Specify) residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E.

June 10, 2009

30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year, State Registrar

Certification:

Medical

29d. Date signed (Month, Day, Year)

Death

Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2009 30 1:10p May Gail E. Wirick /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Rockville Shady Grove Adventist Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea **Funeral** Days Hours Min. 1 □ M 2 🖾 F Illinois Yrs. Feb. 1944 65 429-80-7581 Director Usual Residence of Decedent 10d. Inside City Limits 10b County 10c. City, Town or Location 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 217 No Funeral Director Germantown Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20874 18233 Swiss Circle Apt. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ∐Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ₩ No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Administrative Director 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Unknown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is n any Injury or other traun Tralee Court, Damascus, Maryland 20872 Kenneth V. Wirick/_Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Stauffer Crematory Inc . 3,2009 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 21. Signature of Fureral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes P. A. 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Days **Physician** Respiratory Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Days Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Years physician and the burial-transit Institutional Lung Disease Due to (or as a consequence of): Years Physician/Medical Rheumatoid Arthritis as IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 21 No 3 Probably 4 Unknown 1 ☐ Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Mapher of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

executed Box 68760. pe Ö σ. Division of Vital Records, Hospital or Attending Physician: the

72 hours after death with

3altimore, Maryland 21215-0036

hours after death. filled in by within 24 hours a

To the Funeral I

completely filled

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State Registrar

DHMH 17 Rev 1/2001

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

6 Could not be determined

D53317

200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

16220 Frederick Road #213 Gaithersburg, Maryland 20877 Joseph Ball MD 31. Date filed (Month, Day, Year)

JUN 03 2009



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Of IVI	aryland / Depa <i>Cel</i>	rtificate of De		Reg. Na	2009	19542
Ė	Dhuaiair		1. Decedent's Name (First, Middle, Last)		- 1	2.	Date of Death Month Day		3. Time of Death
	Physicia /Medic		Leonard Steph		Inder 50		06 15	2009	10.42 AM
	Examin	er	4a. Facility Name (If not institution, give street and number		4b. City, Town, or Lo		4c.	County of Death	
-1/			5. Social Security Number 6. Sex 7. A	ge (In yrs. last birthday)	If Under 1 Year	NO/C Under 24 Hrs. 8	Date of Birth	9. Birth	place (State or Foreign
	Funeral Director		5.30cal security Number 0.34 12 M 2 F 57	7 Yrs.		Hours Min.	Date of Birth (Month, Day, Year) CCEMDCE-26,1	Cou	ntry)
4			Usual Residence of Decedent						
	yland how		10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits 1 ☑Xes 2 ☐ No
	e Mai	cto	M.D.	BAITI					1
	or 28	Dire	10e. Street and Number		10f. Zip Code	, 4	10g. Cit	zen of What Cou	
	ath w	ra	2729 E. Praston S		2121		by Vos or No.	14. Race - Ameri	
30	hin 72 hours after death with the Maryland e. "natural", or items 23a or 28a-f show Madical Exonilian must be redified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Armed Forces* 1 □ Yes 2 □ If Yes, Give Year or Dates;	No 1972	Was Decedent of Hisp If Yes, specify Cuban, 1 □Yes 2 ☑No	Mexican, Puerto Ric Specify:	can, etc.)	Black, White, Specify: B/	etc.
5-0036	hour		15. Decedent's Education	16a. Dece	dent's Usual Occupation	on		nd of Business/Ir	ndustry
ر 15	filed within 72 Hygiene. other than "nal ent, the Medic	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	life.	kind of work done dur DO NOT use retired)	ing most of working	Fe	denn/ G	ovement
77	d with giene er tha	Į,	12 grade	TAX					
land	be filed wit ital Hygien d other th event, the	Be (17. Father's Name (First, Middle, Last)		18		First, Middle, Maiden	Surname)	
<u>yla</u>		ဥ	William HADERSON			MARY	KOSS		
Mary	2 sho n and ls m raum		19a. Informant's Name/Relationship (Type. Print)	19b. Mailii	ng Address (Street and				
	s 1 and 2 should f Health and Mer Item 27 Is marke other traumatic		MARY HADERSON	20h Place of Diery			9 /TI MOY		0
Baltimore,	iges of or of lite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, crei	osition (Name of matory or other place) N For EST V.	Dane	39 2001 M.	a M. //.	- m
	it. Pa irtmer irtant injury		21. Signature of Funeral Service Licensee		2. Name and Address	of Facility	Man 2	195/11/11=	2/2/3
Ba	permit. Departi importi any inj		Value Su	6	BeTTS F.	N. CARL	200. La Jane ST,	BA1701	ns)
			23a. Part I. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	line.	ter the mode of dying,	such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition resulting in death)	bral Va.	scular	OCCI	denl		
الخر	/Medical Examiner		Due to (or a	s a consequence of):)				
		آخ.	Sequentially list conditions, b. Due k ra	s a consequence of :	ow				
X	uted d ansit	Examiner	cause (Disease or injury that initiated events c.						
o,	e exec an an rial-tra	EXa	resulting in death) Last Due to (or a	s a consequence of):					
98760	tificate be executed g physician and as the burial-transit	edical	d						
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Rox	the death certific y the attending p ched for use as	Physician/N	23b. Was decedent pregnant 1 Live birth	2 Fetal death 3	Ectopic pregnancy			23d. Date of deli Month	very Day Year
0	the a	/sic	1		Other (specify)				
<u>.</u>	that the ed by detac	Ph	Part II. Other significant conditions contributing to death	but not resulting in the ι	underlying cause given	in Part I.	23e. Did tobacco	use contribute to	the cause of death?
Records,	iclan: The law requires that the de certificate has been signed by the ector, page 2 should be detached	d by					1 ☐ Yes 2	□ No 3 □ Pr	obably 4 Inknown
Ö	w requ	Completed					24a. Was an	24b. Were au	topsy findings available
P P	he lar e has ige 2	Ĕ					autopsy performed?	death?	completion of cause of
	an: T tificat or, pa	ပိ	25. Was case referred to medical			26. Place of Death	1 Pyes 2 No	1 I les	2 2 110
	ysicia s cer direct	To B	examiner?	tient 2 ER/Outpatie	Other		e 5 Residence	6 ☐ Other (Spec	oify)
Division of	or Attending Physician: after death. Director: After this certific in by the funeral director, i	tion: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	jury 28b. Time o lnjury	Work?	at 28 es 2 □ No	d. Describe how inju	ry occurred	
DIVIS	ne Hospital or Attendi 124 hours after death. Le Funeral Director: A pletely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of li	njury - At home, farm, st etc. <i>(Specify)</i>	reet, factory, office	28	Rf. Location (Street a City or Town, Stat	nd Number or Ru e)	ral Route Number,
	Hospita 24 hours Funera etely fille	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the besis and manner: and manner:	of examination and/or in	th occurred at the time nvestigation, in my opi	e, date and place, a nion, death occurre	nd due to the cause(d at the time, date ar	s) and manner as d place, and due	s stated. to the cause(s)
	To the Hos within 24 hor To the Fun completely	Med	29b. Signature and title of certifier		29c. License			ate signed (Monta	
	10				11/7	1784	16	- 16	009
			30. Name and address of persu, who completed cause of	death (Jtem 23a) (Type	, Print)				
	<u> </u>		Kudolph J. Jas	tellanizz	Print) SGreen	54 Ba	Limore	mD.	21201
	Sta Registi		31. Date filed (Month, Day, Year) 32. Regis	trar's Signature	Kol			-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend ItState 25 M264 299 / Department of Health and Mantal Hygiene? For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11:25F_M Day/i Month AY EYERD 9 Opal Armstrong 4b. City, Town, or Location of Death 4c. County of Death imore 4a. Facility Name (If not institution, give street and number) Center 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex Min. 1□ M 🗶 F Months Days Hours 431-44-6292 89 Jan.6,1920 Arkansas Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State 1 ☐ Yes 2 X No Maryland Baltimore Middle River 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 3817 Bayville Road 21220 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐Yes 2 XI If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify. Specify: White 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Housecleaner 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Oscar Wild Comstock Edna Baser 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3817Bayville Road, Middle River, Maryland21220 Margie Sue Upton 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Marked Tree Cemetery6-3-09 Marked Tree, Arkansas 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P. A michael 6009 Harford Road, Baltimore, Maryland21214 Mayne Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CONGESTIVE HEART FAILURE disease or condition resulting in death) Due to (or as a consequence of): ACUTE MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): CORONARY ARTERY DISEASE resulting in death) Last Due to (or as a consequence of): FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Vear 5 Other (specify) 9 Unknown rt II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 **Z** No 1 ☐ Yes 2 ☐ No t □Yes 26. Place of Death (Check only one) examine

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Exeminer must be redified at

Baltimore, Maryland 21215-0036

burial-transit and attending physician for use as the buria signed I page 2 should has certificate After this after death

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

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Examine Certification: To

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9 Unknown 25. Was cas

3 Suicide

29a. Certifier

4 T Homicide

27. Manner

. Was case referre examiner?			
1 Yes 2 XN	0	Hospita	1
Manner of Death		28a	
1 Natural	5 Pending		
2 Accident	investigation	1	

investigation 6 Could not be determined

Hospita	al: 1 🔀 Inpatient	2 🗆	ER/Outpatient	3 🗆 [)C
	a. Date of Injury (Month, Day, Ye		28b. Time of Injury		2

M Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

8c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

MARYLAND 21204

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier

29c. License number D37254

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. D. 7601 OSLER DRIVE TOWSON, POH LIM. BOON

State Registrar

24 hours a Hospital

within 2

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. ∠ 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician 15, 2009 4:34 A M June Nellie M. Armiger /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Charlestown Care Center Catonsville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Days Hours 1 ☐ M 2 🔀 F 212-20-7035 July 10, 1926 Virginia 82 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~-" any injury or other traumatic exercises. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Director Maryland Baltimore Catonsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 709 Maiden Choice Lane RG431 21228 Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔯 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore Gas & Electric 12 Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William G. Williams Ora S. Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 709 Maiden Choice Lane, RGT331; Catonsville, MD 21228 William L. Armiger Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ■ Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 6/17/2009 Woodlawn, Maryland Woodlawn Cemetery 22. Name and Address of Facility Sterling Ashton Schwab Witzke runeral Home of Catonsville, Inc. Signature of Funeral Service Licenses 1630 Edmondson Avenue; Catonsville 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final men Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the first of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) the 9 I Inknown signed by t Id be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy performed certificate 1 2 No Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 1 10 2 ER/Outpatient 3 DOA 1 🔲 Inpatient 2 neral Director: After this filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier Medical On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) within 24 and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD 30 Name and add/ess of person who completed cause of death (Item 23a) (Type, Print) Q 2116 Nada 9 0 SON 5 32. Redistrar's Signature 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

Backs

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 11:21 AM 11 2009 June Carlean Rose Elizabeth Buffington /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8. Date of Birth (Month, Day, Year) Carroll Taneytown Lorien of Taneytown If Under 1 Year | Months Days If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Months 1 ☐ M 2 ☐ XF Maryland Director 80 218-24-9150 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Ex-miner must be notified at 1 Kes 2 No Director Taneytown Carroll MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21787 104 Carnival Drive r death v Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. e filed within 72 hours after dial Hygiene.
other than "natural", or item ☐Yes 2 f Yes, Give 2 XNo 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify If Yes, Give Year or Dates: þ 3 □Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker marked other Department of Health and Bentie Hite Department of Health and Mental Hy, Important: If item 27 is marked other any Injury or other *** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ida Pauline Long Samuel E. Stambaugh, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Taneytown, MD 21787 Roxanne Burrier/ daughter 2120 N. Feeser Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/12/2009 All County Cremation Sykesville, MD 21. Signature | Furneral Service 22. Name and Address of Facility Hartzler Funeral Home allarise Union Bridge, MD 21791 Broadway 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or conditior resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it and leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to of as a consequence of Examiner g physician and as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 2 ☐ No perform rmed? 1☐ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA ို 1 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury at Work? Certification: or Attending 1 Natural 5 Pending investigation ours after death. neral Director: A filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral I

completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatule and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

nth, Day, Year) 32
JUN 18 2009

address of person who completed cause of death (Item 23a) (Type, Print)

22. Registrar's Signature

Discuss B. Sparks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_	1 - For Amend Item 23 a per Maryland 25 a per Maryland C	ertificate of Death	Reg. No.
	Physici	an	Decedent's Name (First, Middle, Last) William H Bouchelle		2. Date of Death Month Day Year June 11 2009 3. Time of Death 1:00 p
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of De	
أغمر			12135 Falis Road	Cockeysville	Baltimore rs. 8, Date of Birth 9, Birthplace (State or Forei
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthda 1 M 2 □ F 63 Yrs.	Months Days Hours Mi	
7	2 .		Usual Residence of Decedent		10d. Inside City Limit
	show	ō	10a. State 10b. County 10c. City, Town or Maryland Baltimore Cockeys		1 □Yes 2 ☑ N
1	28a-f	Directo	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	23a or		12135 Falls Road	21030	U.S.A.
36	or items	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates:	 Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pur 1 ☐ Yes 2 ☑ No Specify: 	(Specify Yes or Noerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
9200-91212	uges I and 2 should be filled within 7.4 hours ariet beauthwith the way faiture. It of Health and Mental Hygiene. It of Health and Mental Hygiene. It deem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, its Modical Examinar must be rediffed a	Completed I	15. Decedent's Education 16a. De (Specify only highest grade completed) 1 (G	cedent's Usual Occupation ve kind of work done during most of w a. DO NOT use retired)	
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and	Mental F arked ot atic ever	o Be	17. Father's Name (First, Middle, Last)		ia Foster
ary T	snould and Men s marke umatic	ဥ	Wilmer Bouchelle 19a. Informant's Name/Relationship (Type. Print) 19b. Ma		Rural Route Number, City or Town, State, Zip Code)
Ž.	and 2 Health a m 27 is her tra				ockeysville, Maryland 21030
Ž ,	pernili. Fages I all Department of Heal Important: If item 2 any injury or other once.		aomotory (l Gardens	Date 200. Location - City or Town, State 16–2009 Timonium, Maryland
Ball	Definit. Fage Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	1050 York Road,	Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 Approximate
, L	hysician /Medical :xaminer		resulting in death) a. Due to (or as a consequence of):	rophic lateral Sc	Interval Between
8760,	one be executed by sician and the burial-transit	lical Examiner	Sequentially list conditions, if any leads to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):		
O. Box 68	attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
rds, P.	unes triat the density the signed by the signed by the side by the	þ	Part II. Other significant conditions contributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unkno
Division of Vital Records,	ine law requir cate has been s page 2 should	Completed			24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No
VITE	certificate rector, pag	Be	25. Was case referred to medical examiner?	Other:	Death (Check only one)
on of	ding rnys	tion: To	1 ☐ Yes 2 ☐ No	e of 28c. Injury at	g Home 5 Residence 6 □ Other (Specify) 28d. Describe how injury occurred
Divisi	al or Attens s after death Il Director: ed in by the	Certification: T	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	to the hospital or Attending Prystoart; The far within 24 burus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, companies to the desired form of the desired form of the desired form. Certifying Physician: To the best of my knowledge, companies for the desired form. Certifying Physician: To the best of my knowledge, companies for the desired form.	or investigation, in my opinion, death o	occurred at the time, date and place, and due to the cause(s)
	vithin your the complex	Ž	29b. Signature and title of certifier WWW DUMMY DUMM	29c. License number D 4 0 6 9	29d. Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Ty 5 G O) 31. Date filed (Month, Day, Year)	LOCH RAVEN	Blud, Balhmure MD 26
	St: Regist	ate rar	11N 18 2009 Leve B. 4	ark	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 26 per verb 2892.06/18/09dhb Reg. No. 1 - For State Registrar Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, I Month 06 **Physician** /Medical or Location of Death 4a. Facility Name (If not institution, gir Examiner nder 1 Year Date of Birth (Month, Day, Year) 03-48-27 7. Age (In yrs. last birthday **Funeral** Min. 559 1 □ M 2 🔀 F 2 Yrs Director 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 28a-f show Department of Health and Mental Hygiene. Institute the state of the st 1 Kres 2 □ No Director 10g. Citizen of What Country? 10f. Zip Oode Street and Number 232 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Black Be Completed by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industr 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Moth (First, Midd 17. Father's Name (First, Middle ၉ Zip Code) Informant's Name/Relationship (Type Parghte 19b. Mailing Address (Street and Number 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 Removal from State 5 ☐ Other (Specify) 4 Donation 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Do not enter the mode of dying, such as cardiac or respiratory arrest Onset and Death mmediate Cause (Final unknown Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi 4a,10e,26 Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 3 Probably 4 Unknown 1 🗌 Yes certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Was a. autopsy performed? 1 Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Daughter's Other: Hospital: 4 Nursing Home 2 No 52 Residence 6 Other (Specify 1∐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this Residence 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Name and address of e of death (Item 23a) (Type_Print) 31. Date filed (Month, Day, Year)

JUN 18 2009 State Registrar

Physician /Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eventine must be notified at any Injury or other traumatic event, the Medical Eventine must be notified at agree.

Be Completed by Funeral Director

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Examine

Physician/Medical

Medical Certification: To Be Completed by

For State	State of Ma	•	Certificate				1. No. 2	nno	1051.0
. Decedent's Name (First, Middle, Las	t)					Date of Death		<u> </u>	3. Time of Death
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a. Facility Name (If not institution, give			4b. City, To	own, or Location of Dea			Λ	unty of Death	1 = 1
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. Social Security Number 6. Security Number 11	7	(In yrs. last birtl		Days Hours Mir	1.	(Month, Day, 1		Cou	ntry)
Isual Residence of Decedent		02				09/03/1	.920		
0a. State 10b. County	rundo1	10c. City, Town	or Location Burnie						10d. Inside City Limits 1 ☐ Yes 2 🖾 No
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0e. Street and Number 7466 Furnace Br	anch Road	Apt. 11	10f. Zip C	21060		10		.S.A.	ты у :
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7. Father's Name (First, Middle, Last)				18. Mother's Na	ame (F	irst, Middle, Ma			
	Oliver Wro	oten		Ar	nie	Kimba	11		
9a. Informant's Name/Relationship (7				Street and Number or I					
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Physician /Medical **Examiner** To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

29b. Signature and title of certified

MD Baltmore 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D027415

WAShington Medical

29d. Date signed (Month, Day, Year)

Center

14,2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1:15 P.M Treva Eleanor Bennett June 3 2009 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Anne Arundel Marley Neck Health & Rehab. Glen Burnie If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Months Hours 1 □ M 2 🕅 F Yrs. 87 Maryland 217 16 0056 05/08/1922 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 No N/A Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21210 4527 Keswick Road 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify 3 ₩ Widowed 4 □ Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Church Volunteer 9th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lewis Harry Bortner Lucy Herndon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Michael Bortner Jr. / 7859 Leymar Road Glen Burnie, Maryland 21060 Grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park | 06/17/2009 | Glen Burnie, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

ral", or items 23a or 28a-f shov Exalcimet must be notified at

"natural"

Health and Mental Hygiene. em 27 is marked other than

Item 27 is other tra

permit. Pages 1
Department of H
Important: If Ite
any injury or ot

Director

Completed by Funeral

Be

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with 1

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Examine attending physician and for use as the burial-trar Physician/Medical signed by the a Completed by s certificate has birector, page 2 s eral Director: After this certific filled in by the funeral director, Be Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed

peen

1 24 hours a

within 24 ho

To the Function

completely

Division of Vital Records, P.O. Box 68760,

IF FEMALE 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 2 No

27. Manne Death

1 W Natural

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 4 Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

Year

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Nonknown

performe 1 ☐ Yes 2 ☑ No

24a. Was an

34b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Date of Injury (Month, Day, Year) 5 Pending investigation 6 ☐ Could not be

and manner stated.

28b. Time of 28c. Injury at 1 ☐Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 122 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifie

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of pers

22. Registrar's Signature

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	1- For Amend Items State of Maryland Depart	gs92,66/PP6/096 ficate of Death	Mental Hygier	те No.2009 19550
	Physicia	ın	1. Decedent's Name (First, Middle, Last) Carole J.	Branick	2. Date of Death	Day Year 3. Time of Death
***	/Medic Examin		4a-Facility Name (If not institution, give street and number)	b. City, Town, or Location of De		4c. County of Death
	Funeral		J. Social Security Hamber	f Under 1 Year If Under 24 H Nonths Days Hours M	Irs. 8. Date of Birth (Month Day, 19)	9. Birthplace (State or Foreign Country) MO
	Director		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locat	ion		10d. Inside City Limits
	e Maryla 8a-f sho	ector		esville	100	1 ☐ Yes 2 📉 No Citizen of What Country?
	th with the 23a or 2 list by m	Funeral Director	10e. Street and Number 6901 Springhill Drive 6901 Springdale Drive	10f. Zip Code 21784	109.	USA
920	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Eval. For court be incliffed at	by Fune	11. Marital Status 1 Never Married 2 Married 1 Never Married 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Moo 1 Yes 2 Moo 1 Yes 2 Who 1 Tyes 2 Who 1 Yes 2 Who 1 Tyes 2 Who	s Decedent of Hispanic Origin? es, specify Cuban, Mexican, Pu]Yes 2 ∑ No <i>Specify:</i>	(Specify Yes or No- lerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	iin 72 ho i. in "natur Madical	Completed by	15. Decedent's Education (Give kin life. DC) Elementary/Secondary (0-12) College (1-4or 5+)	nt's Usual Occupation Ind of work done during most of Indianal NOT use retired)		o. Kind of Business/Industry
	filed with Hygiene rther tha			nk Teller 18. Mother's N	Name (First, Middle, Maio	Banking den Surname)
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, In-M	To Be	nerbert Offe	Address (Street and Number or	ice Mann	ity or Town Stata Zin Code)
	ss 1 and 2 sh of Health and item 27 Is n r other traun		Mrs. Karen Martinez (Executor) 6115 S	.W. Bald Eagle	Drive Palm	City, FL 34980
Baltimore,	Pages 1 nent of H nt: If iter ry or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition cemetery, crematical state of the state of Disposition cemetery, crematical state of Disposition cemeters of	on (Name of or or other place) Cremation 6/		ykesville, MD
Balti	permit. Pages 1 Department of F Important: If ite any injury or ot once.			GHT FUNERAL HO Box 195 Sykesv		P.A. 784
	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on e. ch line. Immediate Cause (Final		diac or respiratory arrest, ysema	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death) a. Due to (or as a consequence of):		,	
	ted	niner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury			
8760,	cate be executed physician and the burial-transit	dical Examiner	that initiated events resulting in death) Last C			
O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and agge 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
rds, P.	quires that en signed b uld be deta			erlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death? 2 □ No 3 □ Probably 4 □ Unknown
al Records,		Completed by				24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
f Vita	Physician: r this certific ral director, I	ro Be		Other:	Death (Check only one)	ce a Xi Other (Specify) h OSPILL
o uo	nding Ph th. : After the funeral	tion:	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 2 Injury 28b. Time of Injury 2	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how	injury occurred
Division of Vital	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification: To	3 Suicide 6 Could not be determined 4 Homicide determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	t, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
	To the Hospita within 24 hours To the Funeral completely filled	Medical C		occurred at the time, date and p stigation, in my opinion, death	place, and due to the cau occurred at the time, date	se(s) and manner as stated. a and place, and due to the cause(s)
	To the within To the comple	Med	29b. Signature and title of contifier	29c. License number	29d	Date signed (Month, Day, Year)
	16		30. Name and address of person who completed cause of death (Item 23a) (Type, Pr	int) (10920	1	00/13/2009
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Blvd. Elde	n, gruda	17 41187
	Registr		1111 1 C 0000 A A A A	/		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20:25 PM Renee rcistine JUNE 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death OF BALTIMORE BALTMORE CITY SINAI HOSPITAL If Under 1 Year | If Under 24 Hrs. 5 Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) 6. Sex 3ex 1 □ M 2 F Min. Months Days Hours 215-74-3778 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1∩a State 10b County 1 □Yes 2 No ?olumbia MD Howar 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Mills Ro 21046 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian Black, White, etc. 1 Tes 2 If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No Specify: Specify: Blac 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) tomemaker Domes 12 HOCOSE 17. Father's Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Surname) irst, Middle, Last) ohnrettinan ra 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Soc Mill M 21244 20c. Location - City or Town, State Ct. Apt. E. Windsor Mill 6 Westbend Shana Harcum/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Owinas Mills, MD 06-25-09 Garrison Forest 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn C. Greene functor SIVS. Vauxh 8728 Liberty Rd. Randallstown, MD 21133 23a. Part1. Enter the di ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hea stature. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final GRAM SEPSIS DAY NEGATIVE disease or condition resulting in death) Due to (or as a consequence of) 3 DAY ENTERO LO CCUIC ANCOMYCIN RESISTENT Sequentially list conditions, ir any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 18 DA4 J. DIFFICELE Due to (or as a consequence of) SEIZURE DISORDER 1 YEAL IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Tilnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SCLEROSIS MULTIPLE 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 ►No VENTILATOR DEPENDENT RESP. 24a. Was an CHRONIC autopsy performed? DIABETES MELLITALS 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending

Examiner YO burial-trar be exect as the l use ō signed by the a o Records, page 2 should Vital of

Division

funeral director, this

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Examiner

Physician/Medical

Completed by

Be

Medical Certification: To

2 Accident

4 Homicide

(Check only

3 ☐ Suicide

29a. Certifier

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evariner must be notified at

12 should be filed within 7 th and Mental Hygiene.
7 is marked other than "r

of Health 27

item 2

= 5 Department or Important: If any Injury or once.

Physician

/Medical

Baltimore, Maryland

PATIENT

Renee

Hospital or Attending death. 24 hours after death Funeral Director: filled in by the completely within 24

State

Registrar

MANDNAY 31. Date filed (Month, Day, Year)

investigation

6 Could not be determined

Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

000

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SINA HOSPITAL OF BALTIMORE MD

1 ☐ Yes 2 ☐ No

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

Registrar

Renner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per of Mas 226/18/29 mell of Health and Mental Hygiene

			1 - State Registrar Certific	eate of Death		Reg. No. 200	9 19554
	Physicia		1. Decedent's Name (First, Middle, Last) NATHAN BREWER		2. Date of De Month	Day Yea	3. Time of Death 1 • 27 A
ا. بر	/Medic Examin			City, Town, or Location of Death	OUNL	4c. County of De	
			77001111 11001111112	BETHESDA nder 1 Year If Under 24 Hrs.	8. Date of Bir	th O.B	GOMERY irthplace (State or Foreign
1	Funeral Director		556-20-0517 XX M 2□F 104 Yrs. Mon	904	NY		
	aryland show	5	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 □ Yes 3(1) No
	the M	recto	MD MONTGOMERY POTOMAC 10e. Street and Number 10e	. Zip Code		10g. Citizen of What (Country?
	3a or	al Di	10800 TARA ROAD	20854	ì	USA	
36	72 hours after death with the Maryland 'natural', or ttems 23a or 28a-f show dical Eventher must be notified at	by Funeral Director	1 Nover Married VV Married 1 Tyes 2 VV	ecedent of Hispanic Origin? (Sp specify Cuban, Mexican, Puerto es 2 Specify:	ecify Yes or No Rican, etc.)	- "	nerican Indian, nite, etc.
21215-0036	hin 72 hours e. an "natural", Medical Exo	eted	(Specify anly highest grade completed) (Give kind of	Usual Occupation f work done during most of work	ing	16b. Kind of Busines	ss/Industry
121	d within 7 giene. r than "i	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	OT use retired)		ME	DICINE
d 2	filed Hyg othe ent,		17. Father's Name (First, Middle, Last)	TERINARIAN 18. Mother's Nam	e (First, Middle	, Maiden Surname)	DICTNE
ılan		To Be	UNKNOWN BREWER	ROSE		JNKN <u>OWN</u>	
Maryland	12 should th and Mer 7 Is marke traumatic		, , ,	Iress (Street and Number or Rui		ber, City or Town, State 20854	e, Zip Code)
	t and Healt tem 2		SANDRA GINSBERG / DAUGHTER 10800 To 200. Method of Disposition 200b. Place of Disposition cemetery, crematory		72009	20c. Location - City	or Town, State
mo	0 0		1 Burial 2 Cremation 3 University State	6-10	-09	ARLINGTON	HTS, IL
Baltimore,	permit. Pag Department Important: I any injury o		21. Signatur of Funeral Service Prense SHALSIVI MENTAL SINIA 890	TAL DARK e Adress Facility O REISTERSTOWN	RD; BAI		21208
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one coose on each line.	mode of dying, such as cardiac	or respiratory	arrest,	Approximate Interval Between Onset and Death
đ	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	FISHIWATION			
4	Examiner		Due to (or as a consequence oi):	FRY DISEASE			YEARS
	n +	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	ecuter and -transi	Examiner	Cause (Disease or injury that initiated events c				1
68760,	ificate be executed g physician and as the burial-transit	al E	But to (at at a consequence of).				
687		ledical	0.				
O. Box	Physiclan: The law requires that the death certific this certificate has been signed by the attending p ral director, page 2 should be detached for use as i	Physician/M		opic pregnancy er (specify)		23d. Date of Month	delivery Day Year
Ф.	that the ned by detac		Part II. Other significant conditions contributing to death but not resulting in the underly	ring cause given in Part 1.	23e. Did	tobacco use contribut	e to the cause of death?
rds	w requires been sign should be	ed by			1]Yes 2 No 3 □	Probably 4 Unknown
of Vital Records,	: The law re cate has bee page 2 sho	Completed			24a. Wa auto per 1 ∐Yes	opsy prior formed deat	e autopsy findings available to completion of cause of h? Yes 2 □No
Vita	siclan: Th certificate rector, pag	æ	25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of Dea			
of	Phys er this eral dir	٦.	27. Many r of Death 28a. Date of Injury 28b. Time of	28c. Injury at		sidence 6 Other (Specify)
ion	Attending For death. ector: After by the funera	atio	1 Natural 5 □ Pending (Month, Day, Year) Injury 2 □ Accident investigation	Work? 1 □Yes 2 □No			
Division	or Attendiater death. Director: Ad in by the fi	Certification: To	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, fi building, etc. (Specify)	actory, office	28f. Location City or To	(Street and Number of own, State)	r Rural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurrence (Check only one) 1 Medical Examiner: On the basis of examination and/or investigand manner stated.	urred at the time, date and place gation, in my opinion, death occu	e, and due to thurred at the time	e, date and place, and	due to the cause(s)
	To the To the compl	Me	29b. Signature and title of certifier	29c. License number	0	29d. Date signed (M	fonth, Day, Year)
) 37	D32881-M	U	6-16-0	
	12V		30. Name and address of person who completed cause of death (Item 23a) (Type, Print 2 150 FEPDS/LUAPIA AVE, PW	WASHINGTOD	06 2	2027	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 15^{Day} Physician JUNE 07:19P M 2009 BAUM SONIA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE ENVOY OF PIKESVILLE PIKESVILLE 9. Birthplace (State or Foreign Country) ROMANIA 7. Age (In yrs. last birthday) 87 Yrs. if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number **Funeral** Hours 1 □ M 2 💢 F 12/16/1921 214-18-7147 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show d 2 should be filed within 72 hours after death with the Maryla th and Mental Hyglene. 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, it is heatest Examinate must be recitled at 1 □Yes 2 No Director BALTIMORE BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21208 3205 TIMBERFIELD LANE Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 □Yes 2 No Specify ģ WHITE 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GERTZ ROSNER BESSIE **ISADORE** ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traun once. 3205 TIMBERFIELD LANE, BALTIMORE, MD 21208 JEROME BAUM / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/17/2009 /17/2009 ROSEDALE, MD SOL LEVINSON & BROS., SHAAREI ZION 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Alunga 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or such that the control of the control o Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ancrah /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). burial-trar Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 9 Unknown After this certificate has been signed by funeral director, page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 26. Place of Death (Check onl one) 25. Was case referred to medical examiner? Other: 4 Horsing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 1 Notural 2 □ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

altimore, Maryland 21215-0036

n 24 hours after death. e Funeral Director: Aft letely filled in by the fur within 24 hor To the Fune completely fi

State Registrar 29a. Certifier

(Check only

29b. Signature and title of certifier

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Millie 25 Mari Smi 31. Date filed (Month, Day, Y 5 Neur 200

2. Registrar's Signature

Ecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

21136

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-04767 State of Maryland / Department of Health and Mental Hygiene **Bridget Banks** 2009 19556 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ June 15, 2009 1645 hrs **Medical Examiner** 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Good Samaritan Hospital Baltimore N If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** oreian Months Hours Min. Director 214-86-0906 Country) M Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 10a State 1 X Yes 2 items 23a or 28a-f show ust be notified at once, SALTIMORE nours after death with the Maryland Funeral Director 10g, Citizen of What Country 10e Street and Number U.S. A 2/2/8 660 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. White, etc. Armed Forces' 1 X Never Married 2 2 X No Yes Specify: BLACK If Yes, Give Year Yes 2 No specify: Widowed Divorced 3 ð 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) YORGAN Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 72 hent of Health and Mental Hygiene. is marked other than MAZUERSITY 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last -05 TER Be (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print.) SELLIEN If item 27 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition Baltimore, crematory or other place 2 X Cremation 3 Removal from State Burial tant: Other Specify Donation 5 22. Name and Address of Facility Beverly 21. Signature of Funeral Service Licenses 2700 Edmondson Ave: BACKY Approximate Interva 23d-Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Cardiac arrhythmia Immediate Cause (Final disease raminer or condition resulting in death) Due to (or as a consequence of) Dilated cardiomyopathy Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical Pi line a-b, PII,27,perME, g893 7/20/09 TT X UNPENDED AMENDED ending physician use as the burial -The law requires that the death certificate be 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months' Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown a Linknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o þ Yes 2 ✔ No 3 Probably 4 Unknown Diabetes mellitus Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? certificate has 1 🗸 Yes 2 Nο ✓ Yes 2 26. Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Hospital: Nursing Home 5 Residence 6 Other Inpatient 2 V ER/Outpatient 3 this 1 🗸 Yes No After th funeral o 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year 27. Manner of Death 28b. Time of Injury Certification: X Natura Yes 2 No Pending Funeral Director: stely filled in by the Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

To the

DHMH 17 Rev 1/2001 **OCME 2006**

State

Registrar

29b. Signature and title of certifier

Donna M. Vincenti, MD

2009

31. Date filed (Month, Day Year

JUN

inn 30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

June 16, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. ZU Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** AM June 15, 2009 315 Dixon Clark /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Rockville Collingswood Nursing Home Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 ☐ M 2 € F April 26, Connecticut 81 Director 044-20-8856 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Madical Examinational be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 ☑ No Director Prince Georges Maryland Laurel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20708 8701 Contee Rd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify Specify: White \$ 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Security Administration 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Louise Martin ၉ Alfred Douglas Dixon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Marc Douglas Clark-son 602 Creekwood Dr., Franklin, KY 42134 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD National Cemetery 6-18-09 Laurel, MD 22. Name and Address of Facility 21. Signature of Fun al Service Licensee Fleck Funeral Home, INC.
7601 Sandy Spring Rd., Laurel, MD.
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MD 20707 Approximate Interval Between Onset and Death Immediate Cause (Final Congestive Heart Failure Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed End Stage Renal Disease attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy Year Month 5 Other (specify) been signed by the should be detached to ∐Yes 2∭XNo 9 Unknown 9 ☐ Unknown 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Osteoporosis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Anaemia After this certificate has funeral director, page 2: autonsy performed? 1 ☐ Yes 2 ☐ No 1 □Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Dursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury 5 ☐ Pending investigation Watural М 1 ☐ Yes 2 ☐ No 2 Accident after death Director; d in by the f 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide thin 24 hours aft the Funeral Di mpletely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 2 Medical Examiner within 2.

State

DHMH 17 Rev 1/2001

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Raman R. Tuli, MD

TON TR SOUR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Charles !

29c, License number

10810 Darnestown Rd, Ste 202, Gaithersburg, Maryland 20878

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) gay 2009 **Physician** 7:15 A Patricia Jane Carter /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. Date of Birth Manth, Dex. Years 1/14/1935 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 XF 74 216-32-0937 Maryland **Director** Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be natified at Yes 2□No Director Bel Air Maryland Harford 10g. Citizen of What Country? 10e. Street and Number United States 21014 555 S. Atwood Rd. Apt 421 Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 X Married Specify: White 1 □Yes 2 No If Yes, Give Year or Dates: Specify: 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) e, Maryland 21215-(Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) **Hospital** Medical Secretary 12 27 Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental Marie A. Pfeiffer William E. Remmey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7125 McNabb Rd., Whiteford, Maryland 21160 permit. Pages 1 and Department of Health Important: If Item 27 any injury or other troonce. Susan A. Mogavero / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/12/2009 | Elkridge, Maryland Meadowridge Memorial 22. Name and Address of Facility Gary L. Kaufman Funeral Home, Inc 21. Signature of Funeral Service License 7250 Washington_Blvd., Elkridge, Md. 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) MECHANICAL DISSOCIATION **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical 23d. Date of delivery ves, outcome of pregnancy 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 🗆 Ectopic pregnancy Year in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a d be detached f P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1□Yes 2 No certificate 1 ☐ Yes Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 210 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ o funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: After To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After Division 1 Natural
2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No completely filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) N. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GATENDY

DHMH 17 Rev 1/2001

State

Registrar

Date filed (Month, Day, Year)

18

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death J Wonth E Year 3:17 A M **Physician** 16 2000 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BACTIMONS HUSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day) 7. Age (In yrs. last birthday) QQ Yrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 M 2□ F **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Wedical Evanturar must be notified at 1 ☐ Yes 2 No Completed by Funeral Director 10g. Citizen of What Country? 10f. Zin Code 21054 Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working)
life. DO NOT use retired Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be and 2 should be မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2809 Department of Health a Important: If item 27 is any injury or other tra once. 20b. Place of Disposition (Name of cemetery, crematory of ther place) 20a. Method of Disposition 1 Burial 2 Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) uneral Service Licens 21. Signature 23a. Party Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or reart failure. List only one cause on each line.

Immediate 5. see (Final disease or or indition resulting in death)

a. Due to (or as a consequence of): **Physician** /Medical Due to (or as a consequence of): Examiner ATRIAL FIBRILLATION Bequestially list our afficie, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): ne The law requires that the death certificate be executed Exami attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 3 Probably 4 Vunknown URINARY TRALT INFECTION 1 ☐ Yes 2 ☐ No certificate has been rector, page 2 shouk 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of 2 🗆 No 2 No 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 NO 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 27. Mann of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Division 1 ☐ Yes 2 ☐ No death. 2 Accident Director: completely filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide after within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2009 30. Name and address of rerson who completed cause of death (Item 23a) (Type, Print) BELVEDERE AVE BALTIMORE 401 RAVITEJ 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

JUN 18

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		State of Maryland / Department State of Maryland / Certification			009 19560
Physicia /Medica Examine	al er	4130 Maple Avenue	Town, or Location of Death	В	2009 3:25 a M County of Death altimore
Funeral Director		5. Social Security Number 219 50 2455 Usual Residence of Decedent 10a. State 10b. County 6. Sex 1 M 2 XF 82 Yrs. 10nde Months 10c. City, Town or Location	r 1 Year If Under 24 Hrs. Days Hours Min.	3. Date of Birth (Month, Day, Year) 05/20/192	9. Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits
e Maryla 3a-f shov	ctor	Maryland Baltimore Halethorpe			1 ☐ Yes 2 🐴 No
th with th	al Dire	4130 Maple Avenue	21227		izen of What Country? U.S.A.
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel" or items 23s or 28s-1 show any injury or other traumatic event, the Medical Exercities must be rolling at once.	Completed by Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes, Spontary Sponta	edent of Hispanic Origin? (Spec acify Cuban, Mexican, Puerto R 2 <mark>本</mark> No Specify:	ican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036 ad within 72 hours all giene. er than "naturel", or if the Medical Exerti			ual Occupation ork done during most of working use retired) s Convent Minis	9	ind of Business/Industry
Maryland 2 Id 2 should be filed in and Mental Hygie Z7 Is marked other traumatic event, it is marked other traumatic event, it is in a should be s	To Be (17. Father's Name (First, Middle, Last) Richard (not available)	(First, Middle, Maiden th Lucille		
re, Maries and 2 shot Health and them 27 is my other traumy		Sister M. Frances Altavilla 4130 Map 20a. Method of Disposition 20b. Place of Disposition (No complete Company of Compa	the same of the sa	Halethorpe	n Town, State, Zip Code) , Maryland 21227 position - City or Town, State
Baltimore, permit. Pages 1 at Department of Hea Important: If item any injury or othe		'4 □ Donation 5 □ Other (Specify) New Cathedra 21. Signature of Funeral Service Licensee 22. Name a	Cem. 06/18	ice Funeral	ltimore, Maryland I Service, P.A. ore, Maryland 21225
P G B B	lical Examiner	resulting in death) Due to r r as a consquency f):	novre novronia		Onset and Death
I Records, P.O. Box 687 The law requires that the death certificate ate has been signed by the attending physoage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic 4 ☐ Pregnant at time of death 5 ☐ Other (state of the pregnancy)			23d. Date of delivery Month Day Year
cords, P.	ed by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying Schole domain.	cause given in Part I.		use contribute to the cause of death?
Vital Record sician: The law requir certificate has been si lirector, page 2 should	Completed by			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
on of sing Phy Jing Phy After this funeral d	ation; To Be	25. Was case referred to medical examiner? 1	28c. Injury at	ne 5 Aesidence 8d. Describe how inju	ry occurred
Divis	Certific	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)	ry, office 2	8f. Location (Street as City or Town, State	nd Number or Rural Route Number, e)
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely tilled in by the	edicai Certification;	29a. Certifier (Check only one) Cartifying Physician: To the best of my knowledge, death occurre control on the basis of examination and/or investigation and manner stated.	d at the time, date and place, a n, in my opinion, death occurre	d at the time, date an	d place, and due to the cause(s)
To t withi To tl	N.		9c. License number		ate signed (Month, Day, Year)
2 1		30. Name and address of serson was completed cause of death (Item 23a) (Type, Print)	10 Guje 1	2 & Syl	12 MD 21228
Stat Registra		31. Date filed (Month, Day, Year) JUN 18 2009 32. Registrar's Signature	,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			For State Registrar	State of I		•		t of H	ealth a		ental Hy	Reg. No.	0000	9 19561
1	Physici: /Medic Examin	al	Decedent's Name (First, Middle, Last) ANN NOVELLA CLARK As Facility Name (If not institution, give street and number)				4b. City,	Town, or	Location	of Death	2. Date of De Month JUNE	15, Day	y Year 2009 . County of Deat	
	Funeral Director		GILCREST HOSPI 5. Social Security Number 6 214-56-7801		Age (In yrs.	last birthday) Yrs.	If Under Months	OWSO 1 Year Days	N If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 9-4-	th ay, Year) 1949	Co	MORE thplace (State or Foreign buntry) RYLAND
	the Maryland 28a-f show	Director	Usual Residence of Decedent 10a. State 10b. County MD • HARFO	RD		y, Town or Lo						10g. Cit	tizen of What Co	10d. Inside City Limits 1 X Yes 2 □ No
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, if a fixedical Evar, five in ust be notified at once.	by Funeral	1911 HIGHPOINT 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force	es? ∐ No			2105 dent of Hi cify Cuba			ecify Yes or No Rican, etc.)		USA 14. Race - Ame Black, White Specify: B	e, etc.
121215-0036	filed within 72 hor Hygiene. Ather than "naturant, the than "naturant.	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) — 12— 17. Father's Name (First, Middle, La	College (1-40	or 5+)	16a. Dece (Give life. PROGR	kind of wo DO NOT u	rk done d se retired	during mos I) NATOR	\	ng (First, Middle	WB.	AL RADIO	
Maryland	2 should be fi and Mental H Is marked ot aumatic ever	To Be	JOHN CARTER 19a. Informant's Name/Relationship	(Type. Print)			_		NC	VELL er or Rum	A BRYA	NT per, City o	or Town, State,	
Baltimore, M	Pages 1 and 2: ment of Health a ant: If Item 27 Is ury or other trai		WILLIAM CLARK (20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	☐ Removal from Sta	GAR	Place of Dispo cemetery, cres	osition (Namatory or o	ne of other place TVE	e) TERAN	IS 6-	24-200	20c. L		Town, State
■ Bal	permit. Pag Department Important: I any Injury o		21. Signature of Eureral Service Lie 23a. Part 1 Enter the disease, or conshoot, or heart failure. List or	emplications that cau	sed the deat	1 ر	721-2	7 N.	MONE	ROE S	T. BAL	rimo	RAL HOM RE, MAR	YLAND 21217 Approximate Interval Between
	Physician and // Medical Examiner the prival-transit the prival-transit the prival-transit was a second of the prival forms of	dical Examiner	Immediaty Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	as a consequence as a c	uence of): uence of):	pla		ny	, E ('em	4		gaset and Berties
O. Box 6	that the death certificate to the by the attending physic detached for use as the b	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		th 2 ☐ Feta nt at time of o	aldeath 3	⊒ Ectopic p ⊒ Other (s		у				23d. Date of de Month	elivery Day Year
Records, P.	w requires that seen signed by should be deta	þ	Part II. Other significant condition	s contributing to deat	h but not res	ulting in the u	underlying o	cause giv	en in Part 1	l.	1 🗆	Yes 2	2	o the cause of death? Probably 4 Unknown utopsy findings available
Vital Rec	sician: The law certificate has b irector, page 2 sl	Be Completed	25. Was case referred to medical						26. Place	e of Deat	24a. Was auto perf 1 Yes	opsy ormed? 2 N	prior to death?	completion of cause of
Division of V	ing Phy T. After this funeral d	Certification: To E	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investiga 2 Accident investiga 3 Suicide 6 Could no determin	28a. Date of (Month,	Injury <i>D</i> a <i>y</i> , Yea <i>r)</i>	28b. Time of Injury ome, farm, st	of M	28c. Injur Worl	y at	No	28d. Describe	how inju	and Number or F	Rural Route Number,
6	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the beaminer: On the bas and manne	is of examina	owledge, dea ation and/or i	th occurre on the nice of the	at the ti	me, date a opinion, de	ind place, ath occur	and due to th	e cause(e, date ar	(s) and manner and place, and du	as stated. se to the cause(s)
5	To th withir To th comp	Me	29b. Signature and title of certifier	hyl	Ėy	w	29	c. Licens	e number	250		29d. D	ate signed (Mor NE/6,	oth, Day, Year)
	* Sta	te.	30. Name and address of person w	y GB	of death (Iter // (gistrar's Signal	m 23a) (Type & 7 C ature	Print)	V- C	the	Cis	St.	B	altr.	nd
	Regist		JUN 18 200	9 Server	U A.	par	lad							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Carl Ervin Clemmons 2009 15 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner n/a Baltimore Union Memorial Hospital 8. Date of Birth (Month, Day, Year) 07/28/1947 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1X M 2 □ F 61 Director 212-48-0249 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Experient must be notified at 1 XYes 2 ☐ No Baltimore Directo n/a 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21218 1600 East 29th Street Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: Specify: Black ል 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event than "na once. Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk Be Lillie Harris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2203 Walnut Bottom Road York, PA 17408 Stacey Clemmons- Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Park Crematory 6.18.2009 Riverdale, MD 21. agn ture of Funeral rentice. John L. Williams Funeral Directors, P.A. 4517 Park Heights Ave Baltimore, MD 21215 P^{ensee}John L.Williams IV licum Approximate Interval Between Onset and Death 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest lock, or heart failure. List only one cause on each line. s lock, or heart failu Immeriate Cause (Final Sepsis **Physician** week resulting in death) /Medical Due to (or as a conse uence of): Examiner Star End Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical signed by the attending I IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 □ Yes 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral dir Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 5 Pending investigation 1 Natural n 24 hours after death.

e Funeral Director; Aft bletely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. within 2 the

DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Zahra Pakba, MO

Union

ORIGINAL

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

AT-2438946

29c. License number

June 15 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Zahra, Pakbaz, MD Memorial Hospital, Balline, mis 21218

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 9 6 3 00 119inia 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Catonsville Charlestown Care Center 8. Date of Birth (Month, Day, Yes Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year) Days Hours Months 1920 Maryland 406-28-6688 88 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b County 1 ☐ Yes 2 No Catonsville Maryland Baltimore 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 21228 USA 709 Maiden Choice Lane, 404S 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Never Married 2 ☐ Married White If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Specify: 3 X Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Medicine Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James McElvoy Magruder Ida Ford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3441 Plantation Grove; Colorado Springs, CO 80920 Frances L. Nussbaum Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Crest Lawn Mem. Garden 6/17/09 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signatore on Juneral Service Lie. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Fnd - Stage Due to (or as a conse juence of): Due to (or as a consequence of): Due to (or as a consequence of): 23d. Date of delivery Year

ysician Medical Examiner

physician

or Attending Physician: The law requires that the death certificate be executed

certific

After this

To the Hospital or within 24 hours after death.

To the Funeral Director: Aft

Division of Vital Records, P.O. Box 68760.

Physician

/Medical

Examiner

10a State

Funeral

Director

28a-f show

Director

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Completed

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7 is marked other than "natural", or items 23a or 28a-f shortranmatic event, the Medical Event increment to nother a

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Event in a round once.

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. E. its Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner

Physician/Medical IF FEMALE: 2 Completed Be

Certification: To

Medical

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

3 Ectopic pregnancy 5 ☐ Other (specify) 9 Unknown

Month

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

and manner stated.

1 Yes 2 No 3 Probably 4 Unknown

25. Was case referred to medical

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

1 Yes 2 No 27. Manger of Death 1 Natural

5 ☐ Pending investigation 6 ☐ Could not be determined

1 □Yes

28d. Describe how injury occurred 2 🗌 No

autopsy

2 No

1 ☐ Yes

26. Place of Death (Check only one,

29a. Certifier (Check only one)

2 Accident

4 Homicide

3 Suicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

711 Maiden

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

ny

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certonsville, mo 21228

State Registrar 31. Date filed (Month, Day, Year) JUN 18

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 40 A M 00 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Mar Birthplace (State or Foreign Country) If Under 1 Year 7. Age (In yrs. last birthday) Date of Birth (Month, Day) Social Security Number **Funeral** Days Min Months 1□M 2□F 3 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10b. County 10c. City, Town or Location State Important; if item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the "Modical Exprinent curst be collibed as 1 Yes 2 No Director Moro 10g. Citizen of What Country? 10f. Zip Code Street and Number Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. 11, Marital Status 2 No 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married filed within 72 hours after 1 ☐Yes 2 No Baltimore, Maryland 21215-0036 Specify. Š 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) Elementary/Secondary (0-12) Department of Health and Mental Hygiene. Important: If item 27 is marked other than College (1-4or 5+) VIGRAGER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be 19b. Mailing Address (Street and Number or Rural Route Number; City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (Daughter) Pkwy 3310 Guynns MD Vonne 20b. Place of Disposition (Name of cometery, cramatory or other place)

Baot St Unuren Cenz Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signal are of Funeral Service Licensee Home va IZZPW. North Aven 23a. Part | Enter he disease or complications that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shown, or the art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) prev **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☑ No 5 Other (specify) signed by the a 9 Hlpknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ⋧ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 autopsy performed 2 No 2 No 1 ☐ Yes 1 ☐ Yes funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No spital or Attendi nours after death. neral Director; A death. investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of ed cause of death (kem 23a) (Type, Print) 30. Name and address of person

State Registrar

State 31. Date filed (1971) 71.8 200

S2. Registrar's Signature

FD WARDS

LOON LOON

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JA

KIM

SOON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

32. Registrar's Signature

29c. License number

22832

5808 MAIN STREET, ELKRIDGE MD 21075

29d. Date signed (Month, Day, Year)

Registrar

31. Date filed (Month, Day, Year) JUN 18 2009

GIZAW WOLDEHIWOT, MD 2434 WIBELVEDERE AVE, BALTIMORE, MD 21215 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryland / Per dr., g8 - State of Maryland / Per dr., g8 1. Decedent's Name (First, Middle, Last)	Certificate of Death	2. Date of Death 3. Time of De	eath			
Physician	Annie Mae Gaston		May 31, 2009 2:50 P	o M			
/Medical Examiner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat	h 4c. County of Death				
	2882 Pebble Beach Drive	Ellicott City	nowaru	Foreir			
neral ector	5. Social Security Number $425-64-9779$ 6. Sex $1 \square$ M $2 \square$ F 7. Age (In yrs. last by $1 \square$ M $2 \square$ F $2 \square$ F $3 \square$	Yrs. If Under 1 Year If Under 24 Hrs Months Days Hours Min.					
	Usual Residence of Decedent	wn or Location	10d. Inside City				
Show	Tou, date	own or Location	10d. Inside City 1 □Yes 2				
offile ecto	Mississippi Lincoln Broo	okhaven 10f. Zip Code	10g. Citizen of What Country?				
the I	1637 Lake Lincoln Road	39601	U.S.A.	_			
iner must be notified	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- 14. Race - American Indian,				
b y	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:	Specify: Black				
dicat E	Α.	6a. Decedent's Usual Occupation (Give kind of work done during most of wo	16b. Kind of Business/Industry				
t, the Medical E	Elementary/Secondary (0-12) College (1-4or 5+)	leacher	Education				
event, in	17. Father's Name (First, Middle, Last)	18. Mother's Na	me (First, Middle, Maiden Surname)				
	George Newton		loward Newton				
a 5	19a. Informant's Name/Relationship (Type. Print)		Aural Route Number, City or Town, State, Zip Code) 210				
ther tra			Drive, Ellicott City, Mar Date 20c. Location - City or Town, State	. У Т			
ury or ot	tX Burial 2 ☐ Cremation 3 ☐ Removal from State	CLESC CEMCCELY	5-09 Brookhaven, Missi	-			
any injury or o	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Ma	rzullo Funeral Chapel, d,Baltimore,Maryland21	P. 2			
ATT.	23a. Part 1. Enter the disease, or combications that caused the death. Dishock, or heart failure. List only one cause on each line.	o not enter the mode of dying, such as cardia	ac or respiratory arrest, Approximate Interval Between	veen			
ician dical	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. The fost Lead Due to (or as a consequence)	LATIC CARDIDVASCULAR		eath			
niner	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence)	ce of):					
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the burial-transit	that initiated events ' c C Due to (or as a consequence of):						
the bur	d						
	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery				
letached for use as Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 1 □ Yes 2 □ No 2 □ Inknown	eath 3 Ectopic pregnancy		_			
be detached by Physic	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resultin	23e. Did tobacco use contribute to the cause of de	eath?				
be be			1 Yes 2 70 3 Probably 4 U				
page 2 should be			24a. Was an autopsy findings a prior to completion of ca	availabl ause of			
e 2		performed? death? 1 Yes 2 No 1 Yes 2 No	. 51				
director, pag	25. Was case referred to medical examiner?	eath (Check only one)					
	1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA November 5 Residence 6 Other (S)						
funeral o	1 Natural 5 Pending (Month, Day, Year)	3b. Time of lnjury at Work? M 1 □ Yes 2 □ No	and a sound that injury occurred				
by the	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home building, etc. (Specify)		28f. Location (Street and Number or Rural Route Numb City or Town, State)	nber,			
	29a. Certifier 1 Certifying Physician: To the best of my knowle	edge, death occurred at the time, date and pla	ice, and due to the cause(s) and manner as stated.	:)			
ompletely fi	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	n and/or investigation, in my opinion, death oc	curred at the time, date and place, and due to the cause(s)	,			
comple	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year) June 16, 2009	29d. Date signed (Month, Day, Year) Tune 16 2009			
I	Les Contro	D51860	June 10, 2007				
6	30. Name and address of person who completed cause of death (Item 23	3a) (Type, Print)					
State		O 1-700 CHARTER TO	ains #700 Coursis mo	210			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25 Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 1 - State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** June 2000 Arlene Louise Geraci /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Battimore of Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) Oct. 10, 1946 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Hours Min. New York Days 123-36-2773 1 ☐ M 2 💢 F 62 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Evanting that by multiple at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Director Carroll Eldersburg Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21784 U.S.A. 6317 Georgetown Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White è 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Evelyn Terry George Carrington ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $1\,1\,9\,4\,9$ 19a. Informant's Name/Relationship (Type. Print) 78018Wildflower Court, Manorville, New York Fred A. Geraci,Jr. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Nation 2 ☐ Cremation 3 ☐ Removal from State Pinelawn, New York PinelawnMemorial 6-11-09 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marzullo Funeral Chapel, P. A 21. Signature of Funeral Service Licensee michael 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or coordications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Day **Physician** /Medical Due to (or as a consequence of): Examiner Vascula Peripheral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of) Examine The law requires that the death certificate be executed oronary and Due to (or as a consequence of): is certificate has been signed by the attending physician director, page 2 should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant et time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Frobably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Hypertension 24a. Was an autopsy performed? Yes 2 No 2.KNo 1 ☐ Yes 1 ☐ Yes 26. Place of Death (Check only one 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ical Certification: To completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 24 hours after death. Funeral Director: A 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide LX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 124726 uena M. of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address 3

State Registrar 2401 W. Belvedere Ave BaltmoreMD4215

M.D.

/32. Registrar's Signature

Velir

Day, Year) 182009

31. Date filed (Month.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 2 per doc g892 6-18-09 vt.
State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 200^{Year} Jumeth Day 8:40a M 9 JOHN S. GRUZS 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Middle River 7501 Clearlake Lane 8. Date of Birth May 5, 12933 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, Days Months Hours Min 1X M 2 □ F MD Yrs 214-30-5738 76 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State Middle River 1 □Yes X□No Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21220 7501 Clearlake Lane USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Myes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐Yes 2 ☐ No Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Beth Steel Elementary/Secondary (0-12) College (1-4or 5+) MillWright 11th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Ceranowska James S. Gruzs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 7501 Clearlake Lane Balto. MD 21220 MAry Helen Gruzs /daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens of Faith 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burja¶ /2 □ Cremation 3 □ Removal from State 6/12/09 Rossville MD 4 □ Denation 5 □ Other (Specify) 22. Name and Address of Facility 300 Mace Ave.Balto. MD Connelly Funeral Home of Essex 21221 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate pulmonay disease five year Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1€ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 □Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 ☐ Homicide telectrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

/Medical Examiner Physician: The law requires that the death certificate be executed and burial-tran Box 68760, attending physician the as use for signed by the a P.0. Division of Vital Records, page 2 s has : After this certification : Hospital or Attending death.

within 24 hours after death

To the Funeral Director:
completely filled in by the t

Physician

Examiner

Funeral

Director

28a-f shov

Director

Funeral

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Completed

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Examine

by Physician/Medical

Completed

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Certification: To

Medical

29a. Certifier

29b. Signature and title of certifier

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, Iro Medical Examiner must be retilited at

tal Hygiene.

Mental

permit. Pages 1 and 2 should be fi Department of Health and Mental I Important: If item 27 is marked ot any Injury or other traumatic even once.

Physician

/Medical

State Registrar

and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

JUN010, 2009

(Item 23a) (Type, Print)

9106 Phulade Iphua Pd. #304 Baltimore MD 2125,
Signature

OHMH 17 Feet 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. U 0 9 Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 9:56 am rances 6 /Medical Town, or Location of Death 4c. County of Deeth 4a Fecility Neme (If not institution, give street end number) Examiner Himore If Under 24 Hrs. Court Old Road 7. Age (In yrs. less birthday) Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Yeer) 5. Sociel Security Number **Funeral** 1□M 20 F Months Min. 220-22-8448 Usuel Residence of Decedent Days Hours Yrs. March 30, 1924 Maryland Director 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Haalth and Mental Hygiene. Important: If Item 27 is marked other than "naturel, or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified as in injury or other traumatic event, the Medical Examinar must be notified. 1 Ves 2 No Director Kesvill 10e. Street end Number Kaltimore 10g. Citizen of What Country? Koad Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race American Indian 11. Maritel Status Black, White, etc. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□ Yes 2 No Specify: δ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) Elementer Secondary (0-12) College (1-4or 5+) Frivate omostic NOKK 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be lobinson Muston Davenport 10 X16 19a. Informant's Name/Relationship (Type, Print) (Deugnte) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Namb of Date Date MD 2 c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/24/09 Cem. Owings Mills, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Fueral Hole, P.A. 35 Josep 2222 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MD 21216 Approximate Interval Between Onset and Death **Physician** CARDIOVASCULAR DISEASE Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical Examiner Due to (or es a consequence of): Examiner The law requires that the death cartificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of) use as 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2X No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2D No Other: 4 □ Nursing Home 5 Residence 6 □ Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 🗆 No 2 Accident Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide To the Hospital or Atte within 24 hours after de To the Funeral Directo completely fillad in by the 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Learnitying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6080 FAILS ROAD STE DOY BALTIMONE, Md SIDOF ,m.D. MCRAG 1 Ams 5

31. Date filed (Month, Dey, Year)

29b. Signature and title of certifier

32. Registrer's Signature

DHMH 16 Rev 6/95

Registrar

10661

30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD.

31. Date filed (Month, Day, Year)

Assistant Medical Examiner

ORIGINAL

111 Penn Street, Baltimore, MD 21201

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #12 Per Figure 2 Maly (1997) Department of Health and Mental Hygiene 2 1 2

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	Examin	er	4a. Facility Name (If not institution, give street and number) SEASON'S HOSPICE @ NORTHWEST HOSP. RANDALLSTOWN						4c. County of Death BALTIMORE			
n de			5. Social Security Number 6. Sec			If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthp	lace (State or Foreign	
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	be liled within 7.2 hours are regain with the wallyal he liled with 4 years and 4 Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examir et must be notified at		6211 HOPETON AVEN	HE			21215				USA	
	ns 23	Funeral		12. Was Decedent Ever in U.	S. 13.		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		ace - Americ	an Indian,	
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Baltimore, Maryland 21215-0036	filed I Hygi other ent, I		17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, N	Aaiden Surna	ame)		
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Ħ	it. Pa irtmer irtant: injury		4 Donation 5 Other (Specify, 21. Signature of Funeral Service Licens			CEMETER	$\frac{Y}{S} = \frac{1}{5} \frac{1}{5} \frac{1}{5}$	7/2009 N. LEVIN				
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic es once.	1	21. Signatur of Funeral Service Licens				STERSTOWN					
			23a. Part 1. Enter the disease, or comp	lications that caused the deat							Approximate Interval Between	
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Sec.	/Medical		disease or condition resulting in death) a. Due to (or as a consequence of):									
	Examiner		Sequentially list conditions	b								
	pg iii	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
	and rrans	Due to (or as a consequence of): The constraint of the constrai								- 1		
8760,	cate be executed physician and the burial-transit											
687	ificate g phys	edical		d								
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<u>Р</u> .	w requires that the dispersion is been signed by the should be detached	Phys	9 Unknown		ulting in the c	indorlying agus a di	van in Part I	23e Did to	bacco use c	ontribute to	the cause of death?	
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3ec	e law has t je 2 s	du						autop: perfor	sy med?	prior to c death?	ompletion of cause of	
<u></u>	n: Th ficate n, pag		25. Was case referred to medical				36 Place of Dea	1 ☐ Yes th (Check only or	2 🖽 No	1 ☐ Yes	2 ∐ No	
₹	or Attending Phystcian: The law requires that the death certific ther death. Director: After this certificate has been signed by the attending p in by the funeral director, page 2 should be detached for use as it.	o Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	TER/Outpatie	nt 3 DOA Ot	hor:	ome 5 ☐ Resid		Other (Spec	atient hospice	
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Ω	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page											
	the Hospital hin 24 hours a the Funeral I mpletely filled	Medical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exan	vsician: To the best of my kn niner: On the basis of examin and manner stated.	iowiedge, dea nation and/or i	nvestigation, in my	opinion, death occu	irred at the time,	date and pla	ce, and due	to the cause(s)	
	To the within 2 To the comple	Mec	29b. Signature and title of certifier			29c. Licer	nse number		29d. Date si			
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	10 /		30. Name and address of person who	completed cause of death (Ite	em 23a) (Type	, Print)	0					
	UV		N.S. Rajapakse, M		St., Su	ite 200,	Keisterst	own, M	1.2	1136		
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Syn	nature	al						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 11 SC PM LEROY GEYER 10 2009 JUNIE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner JOHNS HOPKINS BAYVIEW MEDRAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min July 30, 1918 Maryland 90 220-07-3335 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show d other than "natural", or items 23a or 28a-f show event, the Wedical Examiner out to motified at 1 ∐Yes 2√2 No Director Dunda1k Baltimore Md. 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. 21222 7452 Edsworth Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify Specify: <u>Ş</u> White 3 Widowed 4 □ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Şecondary (0-12) 12th College (1-4or 5+) Truck Driver National Brewing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any linjury or other traumatic event once. Be Mary Henning Conrad Geyer ဨ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Hickory Road Stewartstown, Pa. 17363 Robert Geyer (son) 8364 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 6-15-2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility aczorowski Funeral Home, P.A. 21. Signature of Funeral Service License Tohn 1201 Dundalk Avenue Baltimore, Md. 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final FIBRILLATION 36 HOURS **Physician** ATRIAL disease or condition resulting in death)) /Medical Due to (or as a consequence of): Examiner 40 YEARS HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) I∐Yes 2□No ed by the 9 Unknown 9 Unknow signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 1 Yes 2 No 3 Probably 4 Unknown icate has been significate page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy nerform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٥ funeral 28a. Date of Injury (Month, Day, Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

P.O. Box 68760, Division of Vital Records,

72 hours after death

Baltimore, Maryland 21215-0036

executed certificate be Hospital or Attending Physician: 74 hours after death. Funeral Director: After this certifica the filled in by 24 hours a

To the I within 2 671 Registrar

31. Date filed (Month, Day, Year) State

4 Homicide

29a, Certifier

Medical

29b. Signature and title of certifier Soluuni Louison, 29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

JUNE 10, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940 EASTERN AVENUE BACTIMORE, MD ASHWINI DAVISON MO

and manner stated

JUN 18 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) June 16, ^D2009 Year 17:30 **Physician** Barry Haywood /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Takoma Park Washington Adventist Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 23, 5. Social Security Number 6 Sex 7. Age **68** (In vrs. last birthday) Hours **Funeral** Min. 1940 Months Days 12€24M 2 □ F 244-58-9219 North Carolina Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28s.4 c. any injury or other traumatic event, the Maranese and injury or other traumatic events. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Washington N/A txXes 2 □ No DC Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number United States Buchanan Street, NW 20011 1409 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Specify: Black 1 ☐ Yes 21 No Specify. 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Home Improvement Elementary/Secondary (0-12) College (1-4or 5+) Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hazel Thomas Haywood Lamar ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Buchanan Street, NW, Washington DC 20011 Elnora P. Haywood / wife 1409 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Laurel, Maryland 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/20/2009 MD National Memorial 4 Donation 5 DOther (Specify) 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Puneral Service Licenses 7400 Georgia Avenue, NW, Washington DC 20012 70000 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner mman Sequentially list conditions, ir any, leading to liminediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine executed as the burial-tran atten ling physician and Due to (or as a consequence of) Box 68760, Hospital or Attending Physiclan: The law requires that the d ath certificate be Physician/Medical IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Year sate has been signed by the atterpage 2 should be detached for it Month Day in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 2 1 No 1 ☐ Yes 2 No 1 □Yes 24 hours after death.

Funeral Director: After this certificately filled in by the funeral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1- Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Injury 5 ☐ Pending investigation 1 F1Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) University BLUD East 31. Date filed (Month, Day, Year)

JUN 1 8 2009 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death _Month Year **Physician** 2009 2:5 6AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 7+17 Anne Arundel ilan Burnie Birthplace (State or Foreign Country)
 N.T. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan 9 1915 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Hours Months 125M 2□ F Days MD 94 213-09-1874 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State : if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modical Examiner manake rectified at 1 ☐ Yes 2 ☐ No Director Anne Arundel MD Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 1018 7th Street 21060 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black White etc. 1 □Yes 2X□ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No White Specify Specify: þ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Mechanic International Paper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Swartz Carl Hajek ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health ar permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau once. 1018 7th Street Glen Burnie MD 21060 Mrs. Irene Bajek /Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Atlantic Crematory 2009 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation Signature of Funeral Service Licensee Services 1 2nd Ave. SW Glen Burnie, MD 21061 SUNK M014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pheumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Pulmonary Fibrosis tsbestosis | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician for use as the attending IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) the detached 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by artery disease renal insut 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No tension 24a. Was an has autopsy performed? 1 Yes 2 No certificate 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 ☐ Inpatient this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 1 X Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier া 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

31. Date filed (Month, Day, Year)

JUN 18 2009

Magothy

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First Middle Last) 2. Date of Death Year **Physician** 1244 M HOWARD MARY ALBERTA 2009 JUNE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Howard County General HOspital Columbia 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year 2/28/1924 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1□M 2√2F 85 Marvländ Director 215-18-6577 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show or other traumatic event, the Medical Examiner must be notified at Anne Arundel Jessup Maryland 1 ☐ Yes XX No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 20794 United States 7482 Montevideo Ct. permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23; any Injury or other traumatic event, the Medicial Examines. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □Yes 2√□No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2/12/No White Specify: 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Defense Company Elementary/Secondary (0-12) College (1-4or 5+) Circuit Board Technician 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) Be Walter D. Rider Ethel M. Reck ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1018 Guy Dr., Glen Burnie, MD. 21061 Barbara Broyles/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Name of the state Meadowridge Memorial 6/12/2009 Elkridge, Maryland 22. Name and Address of Facility Gary L. Kaufman Funeral Home, 7250 Washington Blvd, Elkridge, Maryland, 21075 21. Signature of Funeral Service Licenses LM. Broham 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 5EPS IS Immediate Cause (Final **Physician** day disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** PNEU MONT Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner DISEASE or Attending Physician: The law requires that the death certificate be executed PRTERY CORONARY g physician and s the bunal-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 mor Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Records, 2 INSUFFICIENCE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy perform Division of Vital 1 🗆 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of injury 28c. Injury at Work? 28d. Describe how injury occurred .1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral L To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar Sh AKUNIY AC 31. Date filed (Month, Day, Year) GUPTA 9650 SANTIAGO
32. Registrar's Signature

IN 18 2003 Duna B. Carlos

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOOS 3150

TUNE 9th 2009 COLUMBIA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23a State of Maryland Och 18709 ding Health and Mental Hygiene Certificate of Death 1 - For At State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 1:55 2009 01 Hanson June Physician James 4c. County of Death 4b. City, Town, or Location of Death /Medical 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) 8. Date of Birth (Menth, Day, Year Age (In yrs. last birthday) 5. Social Security Number 6 Sex Days -10-Months MARR **Funeral** Director 10d. Inside City Limits Usual Residence of Decedent 10c. City, Town or Location 1 Yes 2 No 10b. County 10a. State show Baltimore item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 10g. Citizen of What Country? 10f. Zip-Code USA 10e. Street and Number Rose Street 21224 233 N. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Funeral 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 11. Marital Status Specify: BLack 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No 1 Never Married 2 Married Specify: Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life: DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Completed warehouse Operator ONK LAST Elementary/Secondary (0-12) College (1-4 or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ed. Th Hedge De Th permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event, Be tanson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mother Rose Street 233 Hanson 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Bacto. 20a. Method of Disposition 109 3 Removal from State 5 2 Cremation 6 REMATERU 1 🔲 Burial meticpeliter charel 5 Other (Specify) 4 Donaxon Facility MINER'S of Funeral service Licensee BROAdway 21. Signature se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or List only one cause on each line. Approximate Interval Between Onset and Death spiratory arrest art 1. Ent if he shock, o heart fa compart ment Immediate Cause (F) al disease or condition abdominal **Physician** Due to (or as a consequence of): resulting in death) /Medical Human Immunodeficiency Syndrome Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transi The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical 68760 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy Month Day 3 - Ectopic pregnancy 23b. Was decedent pregnant 2 Fetal death Live birth in the past 12 months? Pregnant at time of death After this certificate has been signed by the after funeral director, page 2 should be detached for 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. No 3 ☐ Probably 4 ☐ Unknown Completed by Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 26. Place of Death Check only one 25. Was case referred to medical or Attending Physician: å 4 Nursing Home 5 Residence 6 Other (Specify) Other: examiner? Hospital: Inpatient 2 ER/Outpatient 3 🗆 DOA 20 No 28d. Describe how injury occurred မ 28c. Injury at Work? 28b. Time of 28a. Date of Injury (Month, Day Year) After this 27. Manner of Death Certification: Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 1X Natural М 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun 2 Accident the t 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Could not be 3 Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the Hospital 29a. Certifier Medical (check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-000 unousen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 lorowski Jason

DHMH 17 Few 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 18 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Day Year Month Russell J. Hammel, Sr. 2009 16 June 4c. County of Death 4b. City, Town, or Location of Death N/A **Baltimore** If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Hours

For State Registrar 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician 12:21 A.M /Medical 4a. Facility Name (If not institution, give street and number) Examiner Harbor Hospital Center 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1 🛛 M 2 🗆 F 85 218 12 4346 Maryland **Director** 02/23/1924 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits show 10a. State 10b. County r than "natural", or items 23a or 28a-f shov 1 ☐ Yes 2 🛣 No Director Anne Arundel Glen Burnie Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a and Injury or other traumatic access 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 8 Chester Circle 21060 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 [X] Yes 2 □ No If Yes, Give Year or Dates: WW II 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No ≥ Specify: 3 X Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chevron U.S.A. Supervisor 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Hammel Sr. (not available) ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Russell J. Hammel, Jr./ son 833 Sunnyfield Lane Baltimore, Maryland 21225 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State MD_State_Veteran_Cem. 06/23/2009 | Crownsville, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 manue 200 23a. Part. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** HEART FAILURE CONGESTIVE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions, a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) I Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 CANCER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown PROSTATE Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 No 1 ☐Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Erctifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier nury 1 vos 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CTEE ST. BALTIMOTE, MU 2/22)

8+1

State Registrar K-1: DHARMASENA, MW.

21

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** William David Hogan /Medical City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimort sedale 8. Date of Birth 05-04-1921 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign . Age (In yrs. last birthday **Funeral** Massachusetts Hours Months Days 11XM 2□ F 88 016-12-6974 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10b. County 10a, State 1 X Yes 2 □ No Baltimore N/A Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or any Injury or other traumatic event, the Me it al Examiner must be n 21210 U.S.A. 911 West Lake Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 X Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Baltimore, Maryland 21215-0036 Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Church Roman Catholic Priest 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Grace S. Smith Joseph Henry Hogan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Fellow -Priest 1130 N. Calvert Street Baltimore, MD 21202 St Joseph Society Sacred Heart 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 06-19-2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery 21. Signature of Funeral Service Licensee 5305 Harford Road Baltimore, Maryland 21214 Leonard J. Ruck, Inc. an Culson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner etre Sequentially list conditions, Due to (or as ponsequence of): it any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine and I-transit death certificate be executed nowher Due to (or as a consequence of) attending physician a for use as the burial-Division or Vital Records, P.O. Box 68760, Physician/Medical as t IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) sate has been signed by the a page 2 should be detached a 9∏Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 1□ Yes To the Hospital or Attending Physician: 26. Place of Death (Check only one) director. 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Tes 2 No 1 Npatient ို within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director. 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury at Work? Medical Certification: 5 ☐ Pending investigation 1**⊈**Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

Registrar

State

6

DHMH 17 Rev 1/2001

29h. Signature a

d title of certifier

ERASTIAN

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOIAN, M.D

32. Registrar's Signature

29c. License number

00055171

9000 Franklin Square Dr. Baltimore, MD 21237

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 5 am lame /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Joseph Richey Hospice Baltimore N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 24, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours Months 1 X M 2 □ F 78 1931 Maryland Director 217-24-3447 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at 10a. State 1 □ Yes 2√□ No Director Anne Arundel Maryland Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21122 USA 14 Fallon Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 No 1948 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ∐Yes 2 🕅 No Specify. Specify: White ģ 3 XWidowed 4 ☐ Divorced 1951 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Fire Fighter Fire Department 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unk Unk ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1420 Peace Drive Pasadena, Maryland 21122 Brian Kunkoski, Son Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 06/17/09 Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 homal Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): burial-transit Cause (Disease of linju that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760. the attending physician Physician/Medical the IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) signed by the a Id be detached for ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Completed has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificale 1 ☐ Yes 2√ 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)
JUN 18 2009 State

Registrar

Colleges

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 11:31AM hson oroth /Medical 4b. City, Town, or Location of Death Ballimore 4c. County of Death Name (If not institution, give street and number) Examiner Hospita 9. Birthplace (State or Foreign Obuntry) Nary (and 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number 6. Sex **Funeral** Days Hours 1 □ M 2 🗹 F Director Usual Residence of Decede 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Modical Examiner must be rediffed at once. 1 Nes 2 No Director It more 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify \$ 3 Widowed 4 Divorced la Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be honne Herson ပ mono 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Balto. Mr. Arthur MD 21207 ewellen 20c. Lecation - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State Green mount Crematory 9/0 611 5 ☐ Other (Specify) 4 □ Donation 22 Name and Address Facility 222 W. North P. A. 21316 21 Signature Fu eral Service License Maris, L. 1/2 2222 titelle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician hours SEPTIC SHOCK disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 2 days Neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a noneequiring of Examine cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year in the past 12 months?
1 Yes 2 No 5 Other (specify) Johnson, Dorothe 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 🖎 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 □Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) No ER/Outpatient 3 □ DOA 1∐ Yes 1 🔲 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1/Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D2264 JUNE 15, 2009 order and address of person who completed cause of death (Item 23a) (Type, Print) 900 SUTTI CATOR RUENUE BALTIMORE MANYLAND miD SUYDER Jerume 32. Registrar's Signature fled (Month, Day, Year) 31. Date State JUN 18 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1 Per Phy \$1812 of War land Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** THA 11.30 m.M KIM HWA Soon Kim une 2009 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Northwest Hospital Randallstown Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Feb 8,1923 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 ☐ M 2 👿 F *Country)* Korea None 86 Yrs. Director Usuel Residence of Decedent with the Maryland 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location r then "natural", or Iteme 23a or 28e-f show the Madical Examiner must be notified at MD **Baltimore** 1 ☐ Yes 2XXVo Windsor Mill Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7808 Cornerstone Way 21244 Korea filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces?, 1 ☐ Yes 2 (1)No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Asian ð 3 X XVidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be s 1 and 2 should be fit f Health and Mentel H tem 27 le marked ot Unk Unk 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Item 27 I Chang Won Seo (Son) 7808 Cornerstone Way Windsor Mill, MD 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State permit. Pages 1
Depertment of H
Important: If Ite
any Injury or ott Meadowridge Memorial Park 6/20/09 Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, Inc. 7250 Washington Blvd. Elkridge, MD 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause of the line. Approximate Interval Between Onset and Death Immediate Cause (Final GMSTATIC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed attending physicien and for use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 Doo

9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown certificete has been si rector, page 2 should t Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 📈 No the Hospital or Attending Physician: director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 1 ☐ Yes 2 ♥No 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending in Nospies.
In 24 hours after death.
The Funerel Director: After the funerel of t 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 2 Montaned Hospital Cents 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rangarajew

Registrar DHMH 17 Rev 1/2001

State

Ramasivam

JUN 1 8 2009

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

09-04577

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

2009 19583

othy C. Krau		State of Maryland / Department of - For State Certificate of		iygierie Reg. N	in	00 100
Physicia	ın/	1. Decedent's Name (First, Middle,Last) Timothy C. Krauch		2. Date of Death Month Da		3. Time of Death 0459 hrs
edical Exami			4b. City, Town, or Location of Deat	June 9, 2009	4c. County of Death	
		29350 Maple Avenue	Trappe		Talbot	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 220 66 5039 1 Mm 2 F 54 Yrs	If Under 1 Year If Under 24Hr Months Days Hours Mi		1954 g. Bir	thplace (State or Foreign untry) Maryland
nd show any sce.	١	Usual Residence of Decedent 10a. State 10b. County Maryland Talbot Trappe			-	10d. Inside City Limits 1 Yes 2 X No
Marylar 28a-f s	Directo	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	ntry?
th the 23a or notifie		1730 Ocean Gate Way Apt. A 11. Marital Status 12. Was Decedent Ever in U.S. 13. Wa	21673 as Decedent of Hispanic Origin? (5)	Specify Ves or No-	U.S.A.	ican Indian, Black,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	y Funeral	1 X Never Married 2 Married Armed Forces? If Yes 2 X No	Yes 2 X No specify:		White, etc.	
nours a	q pa	during m	nt's Usual Occupation (Give kind of nost of working life. DO NOT use re		b. Kind of Business/	Industry
36 nin 72 l	Completed by	College (1-4 or 5+)	wall Mechanic		Constru	ction
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Com	17. Father's Name (First, Middle, Last)	18.Mother's Nan	ne (First, Middle, Maio		
121 d be fil fental H rarked	o Be	William John Krauch 19a. Informant's Name/Relationship (Type, Print) 19b. Maillin	Sr. Greet and Number of	ertrude I		e. Zip Code)
Baltimore, MD 21215-0036 eemit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", nijury or other traumatic event, the Medical Examiner	ř			Glen Burn		
re, N 1 and f Health f item er trau		1 Buriol 2 X Cremation 3 Removal from State crematory or of	sition (Name of cemetery, ther place)	Date 2	oc. Location - City o	r Town, State
Pages ment of tant: I		4 Donation 5 Other Specify: Bayview C		/15/2009 B		
Balt permit. Departi Import injury			Name and Address of Facility G			e, P.A. yland 21225
Physician		238. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.				Approximate Interval Between Onset and
'Medical :aminer		Immediate Cause (Final disease a. Cocaine intoxication				Death
		or condition resulting in death) Due to (or as a consequence of):				
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause				
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
60, ate be executed hysician and ne burial - transit	al E	d. X UNPENDED AMENDED 23a,27,28a-f,	perME, g892 6/19	9/09 TT		
60, ate be e: hysiciar e burial	Medical	X UNPENDED AMENDED 23a, 27, 28a-I, IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delive	iry
687(ertifica ding pt		23b. Was decedent pregnant in the past 12 months?	etal death 3 Ectopic preg	nancy	Month	Day Year
Box 687 death certifice the attending p	Physician/	1 Yes 2 No 9 Unknown g Unknown	Other (Specify)			
9 . 9	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.			o the cause of death? obably 4 Unknown
S, P quires then signer and be dild be d				24a. Was an		autopsy findings available
COrclaw red	Completed			autopsy performe	ed? death?	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the nate detent. After this certificate has been signed by led in by the funeral director, page 2 should be detact		25. Was case referred to medical	26.Place of Death (Che	1 Yes 2 ck only one)	No 1 🗸	Yes 2 No
of Vital ng Physician: After this certif meral director,	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatier			esidence 6 🗸 Oth	er: Scene
ing Pl		27. Manner of Death 28a. Date of Injury (Month, Dey, Year) 28b. Time of	f Injury 28c. Injury at Work? 1 Yes 2 X No	28d. Describe how	w injury occurred	
Sior Attend r death ector: by the	catic	2 Accident Investigation 6/9/09 unk			eet and Number of F	Rural Route Number, City
Divi	ertifi	3 Suicide 6 X Could not be 4 Homicide determined (Specify) home	201, 12010, 7, 2010	Trappe,	e) 29350 Ma MD 	Rural Route Number, City aple Ave
Division of V To the Hospital of Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medical Certification:	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ (Check only one) 2 Medical Examiner: On the basis of examination and/or investig and manner stated.	urred at the time, date and place, a ation, in my opinion, death occurre	and due to the cause(ad at the time, date an	s) and manner as st d place, and due to	ated. the cause(s)
F. 2 E 8	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (A	Month, Day, Year)
		(Xaulukell)	O.C.M.E.		June 9, 2009	
1		30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Per	nn Street, Baltimore, MD 2	1201		
	tate	31 Date filed (Month, Day Year) 32. Registrar's Signature	- 4	······································		
Regis		JOH TO FOOD SOLL	aki	-		
DHMH 17 Rev 1/2	2001	ORIGIN	AL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item | per doc 5 per fh g892 6-23-09 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Helen I. Knight -HELEN-KNIGHT June 16 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Catonsville St. Josephs Nursing Home 8. Date of Birth (Month, Day, Year)
Aug. 27, 1 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Days Hours Maryland 1 □ M 2 🔀 F 1914 94 218-74-38 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Catonsville Baltimore Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 USA 1222 Tugwell Drive Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 🖾 No Specify: ģ 3 → Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٩ Sarah E. Sauerland <u>William A. Imbach</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1112 Club Drive; Johnstown, PA 15905 Mary Lou Pappert Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cemetery 6/19/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Fund Service LIC# MO1537 Approximate
Interval Between
Onset and Death
HOURS 33. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS Due to (or as a consequence of): RIGHT NECK OF BCESS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? q 1 ☐ Yes 2 3 ☐ Probably 4 ☐ Unknown KIDNEY Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an MENTA autopsy performed 2 NO 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 ☐ Pending investigation Natural 1 □ Yes 2 □ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Physician /Medical **Examiner** the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Division or Vital Records, P.O. Box 68760, attending properties for use as signed by the a d be detached f certificate has be irector, page 2 s director this After within 24 hours after death To the Funeral Director; completely filled in by the

Funeral

Director

r 28a-f show notified at

"natural", or items 23a or

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or iter any injury or other traumatic event, the Medical Examiner and.

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

£100400

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROAD, SUITE DOY, CATONSVILLE, MO 21229 405 FREDRAICH 32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1.15A 2009 Raymond Lombardi JUNE 12 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) ANNE ARUNDEN CHEN BURNIE BALTIMBRE MEDICAL (ENTER WASHINGTON 9. Birthplace (State or Foreign Country) Ohio If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Days 1 ☎ M 2 🗆 F 214 18 3702 88 01/15/1921 Usual Residence of Decedent 0d. Inside City Limits 10h County 10c, City, Town or Location 10a State 1 ☐ Yes 2 X No Anne Arundel Hanover Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21076 U.S.A. 7548 Old Telegraph Road 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify White 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Electronics Industry 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Michael Lombardi Christina N. Lombardi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mount Airy, Maryland 21771 Joyce Wilder / Daughter 5133 Perry Road 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Cedar Hill Cemetery 06/15/2009 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 manususus complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, or conshock, or heart failure List only Immediate Cause (Final YEAR EMPHYSEMA disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions 23d. Date of delivery Month Day Year

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f shov

Director

2

Completed

Be

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item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mc Jical Evantines Trust by writing a

the Maryland

death with

be filed within 72 hours after

Pages 1 and 2 should Baltimore, Maryl

land 21215-0036

burial-transi

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

Certific

Medical

ner

Exami	Cause (Disease or injury that initiated events resulting in death) Last
cation: To Be Completed by Physician/Medical Exami	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant condition
n: To Be Completed	25. Was case referred to medical examiner? 1 Yes 2 No 27. Many of Death
catio	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investiga

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

resulting in death) Last	Due to (or as a consequence or	n:	
	d		-
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	_
Part II. Other significant condition	is contributing to death but not resulting in	the underlying cause given in Part I.	
25. Was case referred to medical examiner?		26. Place of Death (C	2
1 Yes 2 No	Hospital: 1 ■ Inpatient 2 □ ER/Out	tpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	,
27. Many r of Death	28a. Date of Injury (Month, Day, Year) 28b. T	ime of 28c. Injury at 28c njury Work?	d

						24a. Was an autopsy performed? 1 □ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No		
	/			26.	Place of Dea	eath (Check only one)		
H	ospital: 1 Inpatient 2	☐ ER/Outpatient	3 ☐ DOA	Other:	- I ☐ Nursing H	Home 5 ☐ Residence 6 ☐ Other (Specify)		
tion	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	280 M	i. Injury at Work? 1 □ Yes	2 □No	28d. Describe how injury occurred		
t be ed	28e. Place of Injury - At building, etc. (Spe	home, farm, street	, factory, o	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Phys	sician: To the best of my keer: On the basis of exam	nowledge, death of investing and/or investing and/or investing and/or investing and/or investing and	ccurred at stigation, i	the time, on my opinion	date and place on, death occu	ce, and due to the cause(s) and manner as stated. curred at the time, date and place, and due to the cause(s)		

within 24 hours a

To the Funeral I
completely filled

death. hours after death.
uneral Director: A

Registrar

29c. License number

29d. Date signed (Month, Day, Year)

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably

4 Unknown

Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 ✓ Certifying 2 ☐ Medical E

32. Registrar's 9in

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month DSCOM **Physician** 2009 OUISE ease /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) **Examiner** if Under 24 Hrs. 8 Home anos are VUISING 8. Date of Birth 7. Age (In yrs. last birthday) Yrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** Months Days Hours 1 ☐ M 2 🗹 F 177-36-4612 nia 119 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County worle 10a. State treumatic event, the Mudical Examinational be notified at 1 Yes 2 □ No Director 28e-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 or Itams 23a a 01 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces

1 Yes 2 W No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗹 No Specify: Black þ 3 Widowed 4 Divorced "neturel", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Bultimore we filed within 7 al Hygiene. Greater Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) Medical lechnician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) es 1 and 2 should be fit of Health and Mental Hitem 27 is marked of Be Medi unningham SODERT 19a. Informant's Name/Relationship (Type, Prod (Dung hter) 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town, State, Zip Code) Seguoia MD 21215 DSCOM 20c. Localin - City or Town, State 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other Date permit. Pages 1
Department of H
Important: If ite
eny injury or ot
once. 0 * 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility 21. Signature of Funeral Service Licensee Russ Funeral Home Bulto, 140 21216 North 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dechm nesch se Physician /Medical Due to (or as a consequence of): Examiner en when Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner use as the burial-transit Gong resulting in death) Last Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 Welte Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 No 1 Tyes 2 1 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Avursing Home 20 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Date of Injury (Month, Day Year) 28b. Time of Hospitel or Attending Pl 24 hours after death.
 Funerel Director; After the Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide within 24 hours a To the Funerel E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifer MD U D 31464 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. HASHMIMD, SZI N. ENTAW STILITE 30 & BACTIMORE MID 214

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend #10d Pestate of Maryland Department of Health and Mental Hygiene

		1	For State Registrar	State of Ma	ii yiai ia 7		tificate of l	Death	Reg. No. 2009 19587				
	Physicia	an	Decedent's Name (First, Mic ROBERT	die, Last) MICHAEL		l F\	/ENSON		2. Date of Deat	Day 15	2009	3. Time of Death	
2 4 .	/Medic Examin		4a. Facility Name (If not institute					Location of Death			nty of Death		
-			GILCHRIST HOS			- e 1	TOWSON If Under 1 Year	If Under 24 Hrs.	8. Date of Birth			ALTIMORE ace (State or Foreign	
	Funeral Director		5. Social Security Number 213-64-3954	6. Sex 1 M 2 F 7. Age	(In yrs. last b	Yrs.	Months Days	Hours Min.	077307	1951	Count	ace (State or Foreign	
	ס		Usual Residence of Decedent 10a. State 10b. Cour	ity	10c. City, Tov	vn or Lo	cation				10	Od. Inside City Limits	
	Maryl:	tor	MD	N/A	BALT	IMO	RE					1 X Yes 2 X No	
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. It has a second it is marked other than "natural", or items 23a or 28a-f show other traumatic event, if a Me fight Exact instruments by notified at	Director	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Coun		
		eral		12. Was Decedent E		13.1		1215 lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14.	Race - Americ		
21215-0036		by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ M 3 ☐ Widowed 4 ☐ Divorce	Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give	lo		1 □Yes 2 💢 No	Specify:	Rican, etc.)	Spi		HITE	
12-0	"natur	Completed	15. Deced (Specify only hig	lent's Education hest grade completed)	16	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work	ing	16b. Kind o	of Business/Inc	lustry	
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ylaı	ould b Ment narked	P	SYDNEY			ENS		PAULINE and Number or Rui		or City or To	GOLI		
Maryland	rd 2 sh Ith and 27 is n traum		19a. Informant's Name/Relation PAULINE GIL		18							, MD 21215	
re,	s 1 an of Hea item 2		20a. Method of Disposition		20b. Place ceme		sition (Name of matory or other pla		Date	20c. Locat	ion - City or To	wn, State	
ij	Pages ment of tant: If its jury or o		4 ☐ Donation 5 ☐ Other		BETH		MEMORIAL	06/17			LLSTOW		
Baltimore,	permit. Pages Department or Important: If i any injury or once.		21. Signature of Juneral Serv	ce Licensee	7 h		2. Name and Addre	STERSTOWN	DL LEVIN ROAD -				
			23a. Part 1. Enter the disease shock, or heart failure. I	, or complications that caused list only one cause on each lir	10							Approximate Interval Between Onset and Death	
1	Physician		Immediate Cause (Final disease or condition resulting in death)	-a. Comf	Lichae	45	of Su	rgical P	vice	¥	U	uonths	
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68760,	tificate be executed ig physician and as the burial-transit			d									
	# 5° a	Medical	IF FEMALE:										
O. Box	The law requires that the death cert ate has been signed by the attendin age 2 should be detached for use s	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1	2 Fetal dea		☐ Ectopic pregnan ☐ Other <i>(specify)</i> _	су		230	d. Date of deliv	ery Day Year	
о, С	s that i	by Ph	Part II. Other significant con-					ven in Part I.			١.,	the cause of death?	
ord	w requires to be signal should be	ted t	Danat Ce	Il concer	of J	ili	س برار			Yes 2	7*	bably 4 Unknown	
Records,	The law I	Completed							24a. Was autoj perfo	psy ormed?	24b. Were aut prior to co death? 1 □ Yes	opsy findings available ompletion of cause of	
Vital		Be C	25. Was case referred to med examiner?	lical				26. Place of Dea					
of V	ys dir	မ	1 Yes 2 No	Hospital: 1 ☐ Inpati	ent 2 ER/	Outpatie	ent 3 LI DOA		ome 5 Resi			in hospice	
on (ng fte	tion	27. Manner of Death 1/3 Natural 2 Accident	(Adamsh Co		Injury	Wo	ork? ∐Yes 2∐No	EGG. B0001120				
Division	l or Attend after death. Director: /	Certification:	3 ☐ Suicide 6 ☐ Co	uld not be termined 28e. Place of Inj building, et	ury - At home, tc. (Specify)	farm, st	treet, factory, office			Street and i wn, State)	Number or Ru	ral Route Number,	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical Co	29a. Certifier Cert (Check only 2 Med one)	ifying Physiclan: To the best ical Examiner: On the basis of and manner st	of evamination	and/or i	nvestigation, in my	oninion, death occu	urred at the time	, date and p	lace, and due	to the cause(s)	
	To the within To the compl	Me	29b. Signature and title of cer	tifier 0			29c_Licer	nse number	Z	29d. Date	signed (Month	, Day, Year)	
	7		30. Name and address of per	son who completed cause of	death (Item 23	а) (Туре	, Print)	-	,			1-10	
	0		AMEN 3	utry us	in	(701	N Chan	rla 31	10	N OSW	w)	
	St. Regist	ate rar	31. Date filed (Month, Day, Y	son who completed cause of (MANA 1925) ear) 32. Regist	rar's Stanature	back							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2009 **Physician** Month DOROTHY VIRGINIA LEE June 16, 1:30A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 6204 Mossway None Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) April 18, 1 6. Sex 7. Age (In yrs. last birthday) Funeral Days Hours 1 □ M 2 💢 F 91 **Director** 218-03-3802 1918 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits show ral", or items 23a or 28a-f sl 1V∑Yes 2∐ No Directo Maryland N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6204 Mossway Funeral U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc 1 ∐Yes 2 No If Yes, Give Year or Dates: "natural", or if 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2**X** No Specify. Specify: White <u>ک</u> 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed withir nent of Health and Mental Hygiene. int: If item 27 Is marked other than Irry or other traumatic event, Item Ma Elementary/Secondary (0-12) 12 years College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ James Robert Cross <u>Elizabeth Warfield Biddison</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth A. Gaeng (daughter) 907 Thomas Run Road Maryland 21015 Bel Air, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) permit. Page Department o Important: If any Injury or once. Dulaney Valley Memorial Grdns. 6-19-09 Timonium, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, 21. Signature of Funeral Service Licensee 23a. Part 1. Holer the Hease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Inc. 6500 York Road Baltimore, Maryland Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to initial data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 X/No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 100 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one examine: 1 ☐ Yes 2 X No Hospital: Other: 4 \sum Nursing Home Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 🗌 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier TSC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

Division of Vital Records, To the Hospital or Attending Physician: eral Director: / within 24 hours a

> State Registrar

(Check only one)

Stobanie 31. Date filed (Month,

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated.

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Weller

Day,

			For State Registrar	State of Mar	yland			t of H				giene Reg. No.	200	9 195.80	
	Physicia	an.	1. Decedent's Name (First, Middle, Las	t)							2. Date of Dea Month 06	1 2ay	2009	3. Time of Death - 9:30A M	
	/Medic		Mathilda McMahon			— Т	45 00	T	Lagation	of Dooth	06	4c. County of Death			
	Examin	er	4a. Facility Name (If not institution, give 321 University B1		3		4b. City, Town, or Location of Death Silver SPring						ntgome		
	Funeral Director		Social Security Number 6. S	ex 7. Age		st birthday) Yrs.		If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Fore Country) DC						untry)	
7		Í	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	cation							10d. Inside City Limits	
- Paragraph	f shored at	Į.	MD Montgom	erv	Sil	lver S	prin	3						1 XYes 2 No	
d d	r 28a- notifi	irect	10e. Street and Number				<u> </u>	Code				10g. Citizer	of What Co	untry?	
die veile	23a o Ist be	al D	321 University Bl	vd., W #123	3			20901					inited States		
South the Mender	be lied within 72 mous aren beart with the waryan tall Highene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	/ Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married	Armed Forces? 1 □ Yes 2 X No	1 ☐ Yes 2X No If Yes, Give 1			Vas Decedent of Hispanic Origin? (Specify Yes or No f Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes 2♥ No Specify:					Race - Ame Black, White Afr		
215-0035	tural", c	d by	3⊠Widowed 4□Divorced	Year or Dates:		16a, Deced	lont's Heu	oi Occupa	ation			16h Kind	Ame of Business/	rican	
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717	al Hygiene.	omy	Elementary/Secondary (0-12)	College (1-4or 5+)	Subst	ance	Abus	se Co	unsel	lor	Priv	ate		
	ental Hyg ental Hyg ked othe Ic event,	To Be C	Cony Francis Wallace 18. Mother's Name (First, Middle, Last) Jessie Lee Mitchell									rname)			
Mary	perfinit. Pages 1 and 2 should be posturent of Health and Marcel Important: If Item 27 is marked any Injury or other traumatic evonce.	_	19a. Informant's Name/Relationship (Type. Print)		19b. Mailin	g Addres	s (Street a	and Numb	er or Rura	I Route Numbe	er, City or T	own, State, 2	Zip Code)	
Σ,	arid am 27 i		Kevin McMahon / S	on	LOOK DI						Bowie,		0716 tion - City <i>o</i> r	Town State	
Baltimore,	or otl		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □			ace of Disponentery, cren			e)						
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g	Depa Impo any i		A lense M	CAUTE)	71	- 1					, NW, V			-	
	1		23a. Part1. Enter the disease, or com shock, or heart failure. List only	dications that caused to	he death.	. Do not ente	er the mo	de of dyin	g, such as	s cardiac o	or respiratory a	rrest,		Approximate Interval Between	
	hysician		Immediate Cause (Final disease or condition	Pancre										Onset and Death Months	
	/Medical Examiner		resulting in death)	Due to (or as a	consequ	ence of):					400				
	197	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a	consequ	ence of):									
20.	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	00000000	ongo of):									
/60,	cian a	Ē	resulting in death) cast	Due to (or as a	consequ	ence ot):									
-	e X e	dical	•	d											
). Box (attending for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	23c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at t	2 ☐ Fetal	death 3]Ectopic ∣] Other (s	oregnancy specify)	,			23	23d. Date of delivery Month Day Year		
р. О	d by the detached	Phy	9 ☐ Unknown Part II. Other significant conditions	contributing to death but	t nat resu	Iting in the III	nderlying	cause niv	en in Part	ı	23e. Did 1	obacco use	contribute to	o the cause of death?	
Records,	w requires that been signed to should be det	by		Contributing to death ou	THOTTESU	Tung wi tile ui	inderrying	oddoc grv						robabiy 4 ⊠Unknown	
ည် နိုင်	e law r has be je 2 sh	Completed									24a. Was auto		24b. Were a prior to death?	utopsy findings available completion of cause of	
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Vital	s certil irecto	o Be	25. Was case referred to medical examiner? 1 Yes 2X No	Hospital:	nt 2 🗆 F	ER/Outpatier	nt 3DD	OA Oth	OF:		n <i>(Check only o</i> me 5 🏿 Resi		Other (Spe	ecify)	
o i	g Pnys er this eral dir	n: To	27. Manner of Death	28a. Date of Injury (Month, Day	y	28b, Time o		28c. Injur	y at		28d. Describe				
loi E	ath. ath. r: Aft	atio	1 XNatural 5 ☐ Pending investigatio	n	/ cary	прату	М		Yes 2						
Division or	Hospita or Attending Priysician: 4 hours after death. Funeral Director: After this certificitled in by the funeral director,	Certification:	3 Suicide 6 Could not b 4 Homicide determined		ry - At hou . (Specify	me, farm, str /)	reet, facto	ry, office				Street and wn, State)	Number or R	lural Route Number,	
	To the Hospital or Attending Pro within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C		hysician: To the best of miner: On the basis of and manner sta	examinat										
) ;	To th within To th comp	Me	29b. Signature and title of certifler	0		_	2	9c. Licens	e number					th, Day, Year)	
			han	4 Cm				D249	97			6/	17/200	9	
	2		30. Name and address of person who Luis A. Casas, M					ive.	#103	, Lau	rel, M	D 20	707		
A	Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Signa										

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Robert. Manders June 8. 2009 6:33 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Ft. Washington Ft. Washington Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Davs 1√ M 2□ F Months 578-42-1899 86 Yrs December 8, 1922 California Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, It a Tredical Examinant to nother traumatic event, It a Tredical Examinant to an infill of any 1 Ves 2 No Director Maryland Indian Head Charles 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20640 U. S. A. 44 Cypress Place Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No ☐Yes 2 Yes, Give 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White þ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Nava 1 Elementary/Secondary (0-12) College (1-4or 5+) Research Communications Specalist Laboratory 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Richard Lawrence Manders Marie Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 44 Cypress Place, Indian Head, Maryland 20640 Jean C. Manders 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland National Memorial 6/15/2009 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fleck Funeral Home 100 7601 Sandy Spring Road, Laurel, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Box 68760 attending physician Physician/Medical the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy for in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. the 9 Dunknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 □Yes 2 □ 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifies 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 217 No 1 Inpatient 2 R/Outpatient 3 DOA 1 🗌 Yes မ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0053117

State Registrar

DHMH 17 Rev 1/2001

ask

LIVINGSTON RD. FORT WASHINGTON MD 20744

30. Name and address of person who could ted cause of death (Item 23a) (Type, Print)

32. Registra s Signature

nic

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 9 Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death ^{Day} 2009 **Physician** June 14, 7:30 P Mary A Martin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard 8636 Town & Country Blvd., Apt. A Ellicott City If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 11, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1□ M 2XF 1940 Mary land 69 216-34-4061 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Madical Examination and the confided at once. 1 ☐ Yes 2 ☐ No Director MD Howard Ellicott City 10g. Citizen of What Country? 10e. Street and Number death with 21043 United States 8636 Town & Country Blvd., Apt A Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give
Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1X Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify.White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cashier Restuarant 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Elizabeth William Martin 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8729 Lock Bend Dr., Apt. 169, Baltimore, MD 21234 William Martin - Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition □ Burial 2X Cremation 3 □ Removal from State West Arundel Crematory 6-17-2009 Odenton MD 4 Donation 5 ☐ Other (Specify) Ful eral Service licen e 22. Name and Address of Facility Ambrose Funeral Home, /2719 Hammonds Fry Rd., Lansdowne, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final wetasteric Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 □ No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifie D41139

State Registrar Dr. Knight 11065 Little Patuxant Parkway Columbia MD
31. Date filed (Month, Day, Year)
JUN 18 2009 Security A. Annual

30. Name and address the son who completed cause of death (Item 23a) (Type, Print)

Registrar

ack

09-04721								
George Milberry								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2009 19593 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Reg. No Registrar Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day June 13, 2009 2353 hrs Medical Examiner Milberry Alfrey George 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** Good Samaritan Hospital Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Hours Months Days Min CountryMaryland 12/11/1955 Director 214-64-0139 53 Yrs 1 XM 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 X Yes 2 No Baltimore City 28a-f shov Maryland or items 23a or 28a-f sho must be notified at once-Directo 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number U.S.A. 21201 411 Watty Court 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Funeral 11. Marital Status White, etc. Armed Forces's 1 X Never Married 2 2 X No Yes Black Yes 2 X No specify: Specify: If Yes, Give Year Widowed Divorced event, the Medical Examiner "natural", ⋧ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) i. Pages 1 and 2 should be filed within 72 hours rement of Health and Mental Hygiene.

riant: If item 27 is marked other than "natura or other traumatic event, the Medical Examin npleted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 food warehouse laborer 2 12 Com 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Singleton George Alfrey Milberry Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Pnnt) Baltimore, MD 21229 603 N. Chapel Gate Lane Annette Jackson/ sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State New Windsor, MD 6/19/2009 St. James Cemetery Donation 5 Other Specify. 22. Name and Address of Facility Hartzler Funeral Home S e of Funeral Service License New Windsor, MD 21776 011 310 Church St. nrive Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line Death 'Medical Diphenhydramine intoxication Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and 23a,PII,27,28a-f,perME, g892 6/23/09 TT Physician/Medical AMENDED g physician a the burial -XUNPENDED Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be c 24 hours after death. 23d. Date of deliver 23c. If yes, outcome of pregnancy IF FFMALE: Year 23b. Was decedent pregnant in the Month Day 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 V Unknown þ Hypertensive cardiovascular disease; alcohol abuse Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? No 1 V Yes Yes 2 this certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Hospital: Residence 6 Other: Nursing Home 5 Inpatient 2 V ER/Outpatient 3 1 V Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 27. Manner of Death Certification: Yes 2 X No unk Natural Pendina 6/13/09 Director: d in by the f Fd 11:05 Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5697 Purdue Ave. Apt G3, Baltimore, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be 3 Suicide residence (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the within 2 To the 1 one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier June 14, 2009 O.C.M.E. completed cause of death (Item 23a) 30. Name and address of person why 111 Penn Street, Baltimore, MD 21201 Deputy Chief Medical Examiner Jack Titus MD.

DHMH 17 Rev 1/2001 **OCME 2006**

State

Registrar

31. Date filed (Month, Day, Year)

JUN 18 2009

ORIGINAL

32. Registrar's Signature

UCIVIE

amend #5,8,9,11,12,15,16a&b,17,18,&19a&b Per Int G893 7/29709 JH

For State of Maryland / Department of Health and Mental Hygiene State Registrar

Amend Items 24a,25 per dr. 8892,06/18/09dhb

Certificate of Death

Reg. No. 200 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month May 22, **Physician** 2009 11:40 AM M John E. Monk /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6241 Maxwell Drive Suitland Prince George's 9. Birthplace (State or Foreign Country)
North Caroffina If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 411 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 X M 2 □ F 83 246-24-7169 Director Usual Residence of Decedent 04-29-1926 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Expression to other traumatic event. 10d. Inside City Limits 10a State 10c. City, Town or Location 10b. County Director 1□Yes 2□No Prince George's Suitland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6241 Maxwell Drive 20748 USA Funeral unk Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: black Specify: Be Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Chef Navv unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk John Odius Monk Katie King ဥ unk 19a **kir**raan' Mame (Relating tip (Tree Print) Prince George e Police Dept 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8907 Glen Lane Ft. Washington, Md. 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5X1Other (Specify) in state/ Anatomy Board 655 W. Baltimore Street 21. Signiture of Fineral Services wade, 1)1rector Baltimore, MD 21201 23a. Part it Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate C se (Final disease or con in n resulting in death) **Physician** Due to (or as a consequence of /Medical Examiner Sequentially list conditions Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events requires that the death certificate be executed Due ((a) as a consequence of) per lension and the burial-tran resulting in death) Last Box 68760, nse : IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 □Yes 2 □No Ö 9 Unknown is been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? <u>م</u> Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 □Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? page 2 1 ☐Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 No After this certific funeral director, Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D22305 5-28-09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MRS5324 L NEMATI, M.D. 3611 Bround 3611 Branch Ave Temple Hills. MD. 20748 3 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year June Day Physician /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Bultmone Rand allstown Northwest HOSPITAL If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Mar 24, 1913 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min 1 □ M 2 👽 F WV Yrs. 96 083-26-0215 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, that Medical Experience is not be notified at 1 ☐ Yes 2 ☑ No Director Carroll Sykesville MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21784 5606 Woodhaven Court Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status within 72 hours after 1 ∐Yes 2 XX No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2**X** No White Specify. þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) s 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anastacia Wasko Peter Hodawanska 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5606 Woodhaven Court Sykesville, MD 21784 Mrs. Barbara Young (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Charles Cemetery 6/23/2009 Pinelawn, NY 21. Signature of Funeral Service Licenses HATGHT FUNERAL HOME & CHAPEL, P.A. PO Box 195 Sykesvill, e MD 21784 MO0764 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Coronary VASCULAN DISEASE Immediate Cause (Final Athonosiderote **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine and burial-tra Due to (or as a consequence of) P.O. Box 68760, the attending physician certificate be Physician/Medical the as nse yes, outcome of pregnancy
Live birth 2 - Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 3 Ectopic pregnancy Day for (Month Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown cate has been si page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christine 31. Date filed (Month, Day, Year) State 182009 Registrar

Count Rd Randallstown MD 21133 5401 32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician Bertha Moblev 16 2009 3:25p June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Carroll Hospice Dove House Westminster Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, . Age (In yrs. last birthday) 5. Social Security Number Year) **Funeral** Days Hours Months 1 □ M 2 😿 F 88 Yrs. Jan 20 1921 Director 245-26-021<u>4</u> Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State ed other than "natural", or items 23a or 28a-f show event, the Medical Exercitor must be notified at Sykesville 1 ☐ Yes 2 No MD Carroll Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number within 72 hours after death with USA 21784 2810 Kaywood Place Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐Yes 2X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. White þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) item 27 is marked other than other traumatic event, In. W. Elementary/Secondary (0-12) College (1-4or 5+) AM VETS Administrative Support 12 filed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martha Elizabeth Carson Squire F. Golding မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6546 Tydings Road Eldersburg, MD 21784 Mrs. Sylvia Jacobs (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 permit. Pages 1 Department of H Important: If ite any Injury or ot N☐ Burial 2 ☐ Cremation 3 N☐ Removal from State Mt. Airy, NC June 20, 2009 New Bethel Cemetery 4 ☐ Donation 5 ☐ Other (Specify) HATCHT FUNERAL HOME & CHAPEL, P.A. 21. Signature of Funeral Service Licensee Blear P.O. Box 195 Sykesville, MD 21784 Marc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pentoneti **Physician** Acute disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Bowel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transi NOW S and Due to (or a a consequence of): signed by the attending physician be detached for use as the buria Box 68760 law requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has death? 2 2 2 No 1 ☐ Yes 26. Place of Death (Check only one) funeral director, Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Acther (Specify) No. 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes ဥ this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death Certification: 5 Pending investigation (Month, Day, Year) Injury 1 Natural To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 1 ☐Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examiner states knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ca on and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar 29b. Signature and title of certifier

30. Name and address of person

JUN 18 2009

31. Date filed (Month, Day,

CM ath (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

Showsthen

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Physician 12:27 PM June 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day) Hours Min. 97-37-9. Birthplace (State or Foreign Social Security Number **Funeral** 12 M 2□ F Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 28a-f show d other than "natural", or Items 23a or 28a-f show event, the Medical Exemiter must be notified at 1 ☐ Yes 2 ☐ No MD Director Windsox 10g. Citizen of What Country? 10e. Street and Numbe USA Funeral 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □Yes 2 No 1 Never Married 2 Married 1 and 2 should be filed within 72 hours afte Health and Mental Hygiene. em 27 Is marked other than "natural", or I 1 □Yes 2 No Baltimore, Maryland 21215-0036 BlacIf Yes, Give Year or Dates: Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) river 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) Be or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Medford permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau Good ridge/Daughter 19 Wheeler 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ount Crematory Olda3109 Baltimore, MD 22. Name and Address of Family Jouann c. 6 reene sureal sur Greenmount 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee iberty ed. Randallstown, MS 21133 87281 Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 1 Squamons Cell Calcinoma Physician /Medical Due to (or as consequence of): Examiner 065 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner domembe and Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 100 Month Day Year in the past 12 months? 5 ☐ Other (specify) signed by the a ☐Yes 2 12 No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 9 1 □ Xes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2: autopsy certificate 2 🗆 No 1 ☐ Yes 2 ☑ No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred ne Hospital or Attending P n 24 hours after death. ne Funeral Director; After t Certification: 28c. Injury at Work? After 1 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

DHMH 17 Rev 1/2001

To the Pwithin 2

31. Date file (Month, Day, Year)
JUN 1 8 2009

29b. Signature and title of certifier

Mathew

Kerident

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Caton

900

32. Registrar's Signature

29c. License number

3766

Ave

Baltimore

29d. Date signed (Month, Day, Year)

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Jane 11 Mary Norris June /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Frederick Memorial Hospital Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthdav) 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2 🕱 F Yrs. June 14, 79 Director 1929 215-26-1506 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f shov "natural", or items 23a or 28a-f shoradical Examiner must be notified at Director Maryland Frederick Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.
Important; If them 27 is marked other than "nortant; or other than "nortant; or other than "nortant; or other than "nortant." 8130 Dollyhyde Rd. 21771 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No þ If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) switchboard Elementary/Secondary (0-12) College (1-4or 5+) supervisor 11 operator telephone co./college 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Haines Eloise Woerner 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) R. Thomas Norris/ husband 8130 Dollyhyde Rd. Mt. Airy, MD 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Fairmount Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 6/16/2009 Libertytown, MD 21. Signature of Funeral Service Licer 22. Name and Address of Facility Hartzler Funeral Home attarine (Libertytown, MD 21762 11802 Liberty Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** hypertensive cardiovascular disease /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760. Physician/Medical

Director: d in by the f

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Completed

Be

Certification: To

Medical

P.O.

Division of Vital Records,

sulling in death) Last	d):				
FEMALE: 8b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Dat Mo	e of delivery nth Day	Year
rt II. Other significant condition	ns contributing to death but not resulting in t	the underlying cause given in Part I.	23e. Did tobac	co use contr	ribute to the ca	use of death?
clostridium di	fficile enterocolit	is	1 □ Yes	2 🔀 No	3 Probably	4 Unknown

24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 X No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

one)		and manner stated.	
29b. Signature a	title of certifier	1	
191		ausmin	\sim
' X a	My / /	7	

29d. Date signed (Month, Day, Year) 29c. License number D-13971 6/12/09

24a. Was an

2009

Frederick

U.S.A.

14. Race - American Indian, Black, White, etc.

U.S.A.

Specify:

5:01 P

10d. Inside City Limits

Approximate Interval Between Onset and Death

10 yrs.

1 ☐ Yes 2 X No

Birthplace (State or Foreign Country)

Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUN 18 2009

Robert L. Kaufmahn Registrar's Signatu 31. Date filed (Month, Day, Year)

300 W. 9th St. Frederick, MD 21701

State Registrar

within 24 hours a

To the Funeral I

completely filled

park

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician 200 G /Medical 4c. County of Deat 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A zabeth timo Ursing en Birthplace (State or Foreign Country) If Under 1 Year Date of Birth (Month, Day, Social Security Number 7. Age In yrs. last birthday) **Funeral** Days Hours Min. Months 1 ☐ M 2 🗓 F 85 Maryland Yrs. 06/28/1923 213 20 9936 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State show th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinations to a softing at 1 ☐ Yes 2x No Director Anne Arundel Glen Burnie Maryland death with the 109. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 7997 Woodhall Drive 21061 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1∐Yes 2. No Specify. ģ White 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 8th College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Richard Albert Johnson, Sr. Mary Marie Breighner ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important; If item 27 is 1 any injury or other traur once. George T. Norfolk, Jr. / Son Glen Burnie, Maryland 21061 7997 Woodhall Drive 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 06/19/2009 Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Parti. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final days Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner To the Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2**X** No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2 s autopsy perform 2 No 1 ☐ Yes 2 ☐ No 1 🗌 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death

1 Natural

2 Accident 28b. Time of 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: A 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) enue, Baltimore

State Registrar

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Registrar's Signature

MD

Year)

n, Day, Year

31. Date filed Moni

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 12:30 PM 12 2009 Albert A. Nims June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 717 Maiden Choice Lane ST603 <u>Catonsville</u> Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Year) Days Hours 1 ☑ M 2 □ F 92 March 4,1917 New Jersey Director 055-16-9333 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County if Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the find Event has a routhed at 1 ☐ Yes 2 X No Director Maryland Baltimore Catonsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 717 Maiden Choice Lane ST603 21228 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify White ò Specify: 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Aerospace 5+ Engineer 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic event 17. Father's Name (First, Middle, Last) Be Albert A. Nims Viola Estelle Libby ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Nims Daughter Central Park West Apt 8G; New York, NY 10023 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 6-16-2009 4 □ Donation 5 □ Other (Specify) Atlantic Crematory Glen Burnie, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature Funeral Service Lic 23a. Part1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ardiac **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physiclan: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown þ signed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐Yes 2 ☐No 1 ☐Yes 2 ☐No funeral director. 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident completely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maryland 21228 Laidn Chois care (atorsville J 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 18 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death edent's Name (First, Middle, Last) **Physician** June 9.17 PM 14 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner HOSPITAL BALTIMORE AGNES Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 **™**M 2 □ F 217542337 Director Usual Residence of Decedent 10d. Inside Aty Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Marical Examination or other traumatic events. 1 Yes 2 No Director timore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21229 USA Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Black 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sun 17. Father's Name (First, Middle, Last) Be Nichols 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Prin. Woodington mother 606 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 6-20-09 Baltimore 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaughn C. Greene Funeral Services 21. Signature of Funeral Service Licensee 5151 Baltimore National Pike Balti. md 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Shours Immediate Cause (Final INTRA CRANIAL HEMORRHAG Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last buy to for as a consequence of: sician and burial-transit Due to (or as a consequence of): ed by the attending physician detached for use as the burial P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown ENSION Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 21 No certificate 1 ☐ Yes 2 No 1 □ Yes Division of Vital 25. Was case referred to medica examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 \sum Nursing Home 5 \sup Residence 6 \subseteq Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

State Registrar XADHICA N 31. Date filed (Month, Day, Year) JUN 18 2009

NANDI 900 S CATON AVENUE

32. Registrar's Signature

3. Same

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BALTIMORE

21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 9602 Reg. No. Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1:00PM **Aenth** Year **Physician** 2009 then /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner N.H. rvington more QYE Birthplace (State or Foreign
 Gountry) If Under 1 Year Months Days If Under 24 Hrs 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Min Hours 1□M 20 F Maryland 219.30 -9590 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10h County Mount I 10a. State the Medical Examiner must be notified at 1 ₩Yes 2 No Director More or 28a-f 10g. Citizen of What Country? 10f. Zip Code Oe. Street and Numbe Iteme 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 12. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "naturel", or 1 Yes 2 No Black If Yes, Give Year or Dates: Specify Specify: þ 3 Widowed 4 Divorced 16a. Decedent's Usuaf Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) Coflege (1-4or 5+) permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygien. Important: If Item 27 is marked other the any njury or other treumatic 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) illiam Tortu 10 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane Balte 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20 Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Forest 25/09 4 □ Donation 5 □ Other (Specify) 21. Signature of Puneral Service Licen 22. Name and Address of Facility evaltens alton MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) TROKE VEARS **Physician** /Medical Due to (or as a consequence of) Examiner ATHEROSCLEROTIC CARDIOVASCULAR

Due to (or as a consequence of):

DICTOCT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine DISEASE use as the burial-transit certificate be executed Due to (or as a consequence of) the ettending physicien Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 No 5 Other (specify) 4☐Pregnant at time of death Division of Vital Records, P.O. ete has been signed by the epage 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? INSULIN DEPEN DANT DIABETES MELLITUS 1 Yes 2 No 3 Probably 4 Unknown Completed PERIPHERAL24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ARTERY DISEASE, VASCULAR DISEASE, MULTIPLE DECUBITI 2 X No To the Hospitel or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifice 25. Was case referred to medical examiner? 6. Place of Death Check only one Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Naturat Injury 5 Pending 1 Yes 2 No investigation 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0018362 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
KOMADK, DANG M.D., S455, WI KENS AVE. SHE LIO, Balfo.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

IIIN 18 2009

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2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State o	f Mary		epartment of C <i>ertificate o</i>			ental Hy	giene Reg. No.	0000	106	505
	Division		1. Decedent's Name (Fin		st)						2. Date of De	eath		3. Time of De	eath
	Physicia /Medic		Lauren Le								June	Day 8		3:10	P M _
	Examin	er	4a. Facility Name (If not 6806 Red Be	_	e street and nu	mber)		4b. City, Town		of Death		4c.	Howard	1	
	Funeral		Social Security Number	er 6. S		7. Age (In	yrs. last birth	day) If Under 1 Yes	ar If Unde	er 24 Hrs.	8. Date of Bi	rth	9. Birth	place (State or I	Foreign
	Director		217-32-5618		X M 2□ F		74 Y	rs. Months Day	is Hours	IVIII).	May 15,	1935	Mary.	and	
pue	Mo N		Usual Residence of Dec 10a. State 10b	cedent c. County		100	c. City, Town	or Location				_		10d. Inside City	Limits
Man	a-f sh	ctor	Maryland	Howard			Cla	rksville						1 ☐ Yes 2	XXNo
vith th	or 28	Dìre	10e. Street and Number 6806 Red		-d			10f. Zîp Code	÷ 21029			10g. Cit	izen of What Co		
eath v	IS 238	Funeral Director	11. Marital Status	berry No.	12. Was Dece	edent Ever	in U.S.			Origin? (Spe	cify Yes or N	0-	14. Race - Amer		
3-0030 72 hours after death with the Maryland	popuration of leath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be nutflied at once.		1 Never Married	2☐ Married	Armed Fo 1 ∐Yes If Yes, Gi	rces? 2 😿 No		If Yes, specify C			ĭ, Puerto Rican, etc.) Black, White, et				
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DI Pe file	ital Hy d oth	Be	17. Father's Name (First, Middle, Last) Lauren Wolf Pryor						18. Mot		(First, Middle		,		
	nd Mer marke matic	욘	19a. Informant's Name/		Timo Print)		10b	Mailing Address (Stre	at and Num				e Robison	in Code)	
	alth ar 27 is r trau		Laura Ley	(Daughte			7.0	Steple Cha						,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
ore,	of Hear fitem r othe	1	20a. Method of Dispositi	ion		State 2		Disposition (Name of crematory or other to the community of the community			ate		ocation - City or	Town, State	
Dallimor	tment tant: I		4 □ Donation 5 □	Other (Specif	v)	State	Garden:	5		6-12-2		Marr.	iottsville	e, MD	
Dermi Dermi	Depar Impor any ir		21. Signature of Funera	al Service Licer	see	-		22. Name and Adwitzke Fund 5555 Twin	dress of Factors House	mes, Ir Road	nc. Columbi	a Mar	ryland 21	.045	
			23a. Part1. Enter the di shock, or heart fai	isease, or com	olications that o	caused the	death. Do n						ryskiid 2.	Approximate Interval Between	een
PI	hysician		Immediate Cause (Fina disease or condition		25.5	USTAT	< -DI	ropez Cau						Onset and De	ath
	Medical xaminer		resulting in death)			1.5.3 (8)	nsequence of):							
		er	Sequentially list conditions, if any, leading to himinociate cause. Enter Underlying Cause (Disease or injury that initiated events												
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e dear	the att	sician/M	in the past 12 mon 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			nant at tim		5 Other (specify					Month	Day Ye	ar
that th	ed by detacl	, Phy	Part II. Other significan	t conditions	ontributing to d	eath but no	ot resulting in	the underlying cause	given in Par	t I.	23e. Did	tobacco	use contribute to	the cause of dea	ath?
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law re	as bee 2 sho	Completed									24a. Was	s an opsy	24b. Were au	topsy findings av	vailable
The The	cate h	Con									perl 1 ∐Yes	ormed?	death?	2 □No	
VILC sician	certifi rector,	Be	25. Was case referred to examiner?	o medical	Hospital:				Othor:		(Check only				
2 4	er this	n: To	1 ☐ Yes 2 📉 No 27. Manner of Death		28a. Date	of Injury	28b. Ti	batterit 3 1 DOA	4 ∐ I njury at √ork?		me 5 //Res 28d. Describe		6 ☐ Other (Spe ry occurred	cify)	
ondin o	ath.	atio	2 Accident	Pending investigation	1	nth, Day, Ye	ar) in		vork? □Yes 2[□No					
or Atte	fter de Directo in by ti	Certification:	3 ☐ Suicide 6 4 ☐ Homicide	Could not be determined	28e. Place	of Injury - ing, etc. (S	At home, fari Specify)	n, street, factory, office	e	2		(Street ar own, State	nd Number or Au e)	ıral Route Numb	er,
spital	ours a		29a. Certifler 1	Certifying Ph	ysician: To the	e best of m	y knowledge,	death occurred at th	e time, date	and place.	and due to th	e cause(s	s) and manner a	s stated.	
he Ho	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical			niner: On the b		amination and	or investigation, in m							
70 t	To t	Z	29b. Signature and title	of centifier	tu	()		29c. Lice	ense numbe			29d. Da	ate signed (Mont	h, Day, Year)	
			Nicho	Kunk	w.		/lane oc : =	U	5856	7	/	JU	lue 4	any	
			NICHOLAS	11 1 1	ebus 100	55 Lix	He Da	ype, Print) tuxent T	ackur	ay Cul	lemb,	IA M	nury la	hy	
	Sta		31. Date filed (Month, D	ay, Year)	32. F	Registrar's	Signature								
	Registr	ar	JUN	18 2009	1 News	was	13. 1	CALL SOL							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 7:45 P M 06 12 09 Charles J. Peterson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 15910 Kerr Road Laurel Prince Georges If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Dec. 7, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min **X**X M 2 □ F Ĩ933 Minnesota 75 **Director** 474-32-0787 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Experimental process. 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 X No Director Prince Georges Laurel Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20707 Funeral 15910 Kerr Rd Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 XYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 □Yes 2 🙀 No Specify: ģ Specify: 3 Widowed 4 Divorced White Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US Govt 5+ <u>Military Intelligence</u> 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Dororthy Evelyn Turner ပ Jack Goodwin Peterson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lanny Peterson- wife 15910 Kerr RD, Laurel, MD 20707 20c Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Atlantic Crematory 6-16-2009 Glen Burnie, MD 4 ☐ Donation 5 ☐ Qther (Specify) ^{22. Name and Address of Facility}
Fleck Funeral Home, INC.
7601 Sandy Spring Rd., Laurel, MD 20707 21. Signature of Fune of ervice Licensee M01234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** month /Medical Due to (or as onsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (15 ass or filling that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) burial-Division of Vital Records, P.O. Box 68760, physician s the burial Physician/Medical attending p for use as t 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) □Yes 2□No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? /es 22No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation n 24 hours after death.
ne Funeral Director; A
pletely filled in by the ft 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2000 30. Name and address of person wito completed cause of death (Item 23a) (Type, Print) Clement Knight, MD 11065 Little Patuxent Parkway, Columbia, MD 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

		Pleas	e Type or Pri							gible.		
		For State Registrar	State of M	aryland		artment of r <i>tificate o</i>	Health and f Death		giene Reg. No.	009	19605	
Physicia	n	1. Decedent's Name (First, Middle,	Last)					2. Date of Dea Month	Day	Year	3. Time of Death	
/Medic		Marian		Penoye	r	4h Cib. Tourn	or Location of Deat	June 15	-	9 Inty of Death	3:27 P M	
Examine	er	4a. Facility Name (If not institution, Gilchrist Cen				Tows			Baltimore			
Funeral			6. Sex 7. Ag	e (In yrs. lası		If Under 1 Year Months Day	r If Under 24 Hrs		y, Year)	9. Birth Cou	place (State or Foreign	
Director		216-16-3741 Usual Residence of Decedent	1□M 2\\ F	85	Yrs.			Sept 6		Mar	ryland	
yland Now		10a. State 10b. County		10c. City, 7	fown or Lo	cation					10d. Inside City Limits	
r 28a-f show	Director	Maryland Balti	more	P	hoen	ix					1 ☐ Yes 2 🕅 No	
章 0 質	Dire	10e. Street and Number				10f. Zip Code				of What Cou	intry?	
leath w	Funeral	14202 Jarrettsv 11. Marital Status	ille Pike	Ever in U.S.	13.		. 131 f Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or No		USA_ Race - Ameri		
after d		1 ☐ Never Married 2 ☐ Marrie	Armed Forces? 1 ☐ Yes 2 ▼ If Yes, Give	No	10			to Rican, etc.)		Black, White, ecifv:	etc.	
72 hours after natural", or ite	d by	3 X Widowed 4 □ Divorced	Year or Dates:			1 □ Yes 2 📉 N				of Business/Ir	hite	
in 72 h	olete	15. Decedent' (Specify only highest	grade completed)		16a. Dece (Give life.	dent's U sual Occ <i>kind of work dor</i> DO NOT use reti	cupation ne during most of wo red)	rking	160. Kind c	of Business/if	ndustry	
filed within Hygiene. sther than "ent, the Me	Completed	Elementary/Secondary (0-12)	College (1-4or	0+)		Homemake				wn Hom	e	
# H # E	Be	17. Father's Name (First, Middle, L	ast)				18. Mother's Na	me (First, Middle,				
2 should be filed and Mental Hygir is marked other raumatic event, traumatic event, event	မ	Charles E1 19a. Informant's Name/Relationsh	mer Nau		10b Maili	ng Address (Street	Mary et and Number or R	Belle		Jackso		
nd 2 sl alth an 27 is i		Robert A. Penoy					ttsville				21131	
of Hea		20a. Method of Disposition		20b. Plac		osition (Name of matory or other p		.8/09		ion - City or T	own, State	
Page iment tant: It		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp			tnut	Grove C	hurch Cem		Phoen	ix, Ma	aryland	
permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic es		Signature Funeral Service L	icense leve	1	. 1	2. Name and Ad Lemmon I 10 W. Pa	dress of Facility Funeral Ho adonia Roa	ome of Du	ılaney nium,	Valle MD 21	y Inc. 093	
		23a. Part 1. Enter the disease, or of shock, or heart fallure. List of	complications that cause only one cause on each I	the death.	Do not en	ter the mode of	lying, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death	
Physician		Immediate Cause (Final disease or condition resulting in death)	-a Coinc	LICA		OF	FAL		<u>.</u>		DAYS	
// /Medical Examiner			11:	a consequer		DUSEAN	E		\		YEARS	
D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	a consequer		1 0			D.C.	41		
executed n and ial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Nu to (or as	a consequer	nce of):	. b frac	tules	00000	700	5~, 1		
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tificate b ng physica as the bu	ledic		1					Lylling	MD			
eath cert attending for use a	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 1% months?	23c. If yes, outcome 1 Live birth	2 Fetal d	eath 3[☐ Ectopic pregna		24:1:5	23d	. Date of deli Month	ivery Day Year	
that the de ned by the a detached f	Physician/Medical	1 □ Yes 2 No 9 □ Unknown	4 ☐ Pregnant 9 ☐ Unknown	at time of dea	ith 5L	Other (specify		-				
	by Ph	Part II. Other significant conditio	ns contributing to death I	out not resulti	ng in the u	nderlying cause	given in Part I.	23e. Did 1			the cause of death?	
w requires to seen signs should be	ted							1 🗆	Yes 2	No 3∏ Pr	obably 4 Unknown	
e law has b	Completed							24a. Was auto	an 2 psy ormed?	24b. Were au prior to d death?	topsy findings available completion of cause of	
		25. Was case referred to medical					26 Place of De	1 ☐ Yes	2 X No	1 ☐ Yes	2 □ No	
Physicia this cer al direct	ro Be	examiner? 1 Xyes 2 □ No	Hospital: 1 ☐ Inpat	ient 2 EF	R/Outpatie	nt 3 DOA	74h			Other (Spec	city) hospice	
5 5 5	ou:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Inj (Month, D		8b. Time o		njury at Vork?	28d. Describe	how injury o	ccurred		
death ctor: y the f	ficat	Accident investig 3 Suicide 6 Could n 4 Homiside determi	ot be 290 Place of In	iurv - At hom	12 30 e. farm, st	reet, factory, office	□Yes 2 No	28f. Location	Street and N	lumber or Ru	ıral Route Number,	
al or As after	Certification: To	4 ☐ Homicide determi	building, e	tc. (Specify)	tomo			14202	wn, State)	ville Pik	e Phoenix MD	
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	edical (29a. Certifier Check only one) Check only	g Physician: To the bes Examiner: On the basis and manner s	of examination	edge, dea on and/or in	th occurred at the	e time, date and pla ny opinion, death occ	ce, and due to the curred at the time	e cause(s) ar , date and pl	nd manner as ace, and due	s stated. to the cause(s)	
To the To the To the Compl	Me	29b. Signature and title of certifier	٨			29c. Lic	ense number	7		signed (Monti		
}		Mina	lin				5830	>	JUNS	16 2	007	
121		30. Name and address of person of AALON J CHA	who completed cause of			Print)	4 CT TO	Nosh	M			
Sta		31. Date filed (Month, Day, Year)		rar's Signatui	re							
Registr	ar	JUN 18 2009	Cenard	1. 14	a Constant							

DHMH 17 Rev 1/2001

Examiner P.O. Box 68760. Division of Vital Records. al or Attending F after death.

burial-transi nding physician a use as the burialcompletely filled in by the funeral director, After after death. within 24 hours a To the Funeral L

Physician

/Medical

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Certification:

Medical

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Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any nigury or other traumatic event, It is Medical Examiner must be reditional anone.

Physician

/Medical

Baltimore, Maryland 21215-0036

25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturai 1 ☐ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. asemonyalam 29d. Date signed (Month, Day, Year) 29c. License number

AT 2438946

JUNE 15, 2009

Hospital

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASHA SASIMANGALAM MD UNION MEMORIAL HOSPITAL, BALTIMORE, MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Items 10d, 20c per fh, 8892,06/18/09dhb
State of Maryland / Department of Health and Mental Hygiene
Amend Item 8,23a per fh/dhb, 2892,06/18/09dhb

Certificate of Death

Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** la Bertha /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Granville Koga Itimore ear | If Under 24 Hrs. 8. Date of Birth 2/ (Month, Day, Year, State or Foreign 5. Social Security Number s. last birthday) **Funeral** Months Days 1 ☐ M 2 🔽 F 148-26-822 Usual Residence of Decedent 90'rs Director the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it e Modical Examiner ment to notified at 1 Tes 2X No Funeral Director Daltimore ltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number illed within 72 hours after death with Granville 2120 USA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 2 No 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Black Specify: Be Completed by 3 ₩Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Health and Mental Hygiene. em 27 is marked other than ' College (1-4or 5+) OOK 18. Mother's Name (First, Middle, Maiden Surna 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Williams omas ပ Mammie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GranvilleRd Department of Health a Important: If item 27 is any Injury or other tra once. arius Check Balto. 1157 Grandson mb 21207 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fair lawn Cemokny Date 20a. Methed of Disposition awn Cemokin (99/09 Fair lawn, 103)
22. Name and Address of Facility Vaughn C. Orreine Funeral Serv 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Nat'L Pike Balto. MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Congestive Heart Failure Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending IF FEMALE: ise s 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year for in the past 12 months? 1 ☐ Yes 2 🗷 No 5 Other (specify) P.0. ed by the detached i 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. Records, Completed by pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Physician: The law has autopsy certificate 2 No 2 X No 1 ☐ Yes Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To of this funeral (28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Division Hospital or Attending 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the? 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier same and orders of person who completed caus of death (Item 23a) (Type, Print) Seanne 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUN 18 2009 Registrar

DHMH 17 Rev 1/2001

Examiner law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, for signed by the a cate has been si page 2 should b certificate funeral ne Hospital or Attending Pin 24 hours after death. To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Physician

/Medical

Examiner

Funeral

Director

28a-f show

death 1

filed within 72 hours after

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Pages 1 and 2 27

3altimore, Maryland 21215-0036

Director

Funeral

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Physician/Medical

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Certification: To

Medical

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "Nedical Exeminar overt by notified a

and Mental Hygiene.

Department of Health Important: If item 27 any Injury or other to once.

Physician

/Medical

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death 6 Could not be determined 3 Suicide 4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature een f

JUN 18 2009

and manner stated.

29c. License number RES 00129d. Date signed (Month, Day, Year) 2009 JUNE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AIBAK HANEEN 31. Date filed (Month, Day, Year) State

29a, Certifier

HARBOR HOSPITAL 3001 S. HANDVER STREET BALTIMORE 21225 3. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / D	epartment of Hea Certificate of De		tal Hygie Reg.	/ 11 1 1	19609
			1. Decedent's Name (First, Middle, Last)			ate of Death	Day Year	3. Time of Death
	Physicia /Medic		BENJAMIN GREEN RASKOB			June	17, 2009	6:10A [™]
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Loc	ation of Death	i	4c. County of Death Balti	mo no
100			Gilchrist Hospice Care 5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Towson	Under 24 Hrs. 8, [ate of Birth		nlace (State or Foreign otry)
	Funeral				lours Min. Dec	Date of Birth Month, Day, Ye	922 Dela	ware
	Director		Usual Residence of Decedent					
	ylanc	_	10a. State 10b. County 10c. City, Town	or Location			1	0d. Inside City Limits 1 □ Yes 2 □ No
	r 28a-f show	cto	Maryland Baltimore Baltim			100	. Citizen of What Cour	1 □ Yes 2 □ No
	ी 9 2	Dire	10e. Street and Number	10f. Zip Code 21212		Tog.	USA	шу.
	s 23a	eral	420 Overbrook Road 11 Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispa If Yes, specify Cuban, M	anic Origin? (Specify	Yes or No-	14. Race - Americ	
036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Modical Experient must be notified at	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 🕅 Married 3 □ Widowed 4 □ Divorced 12. Was becedent Ever in 0.5. Arried Forces? MYes 2 □ No WW I I If Yes, Give Year or Dates:		Mexican, Puerto Rica	n, etc.)	Black, White,	ite
2-0	72 hours "natural";	eted	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupatio (Give kind of work done durin life. DO NOT use retired)	n ng most of working	16	b. Kind of Business/In	dustry
21	ithin 7	mple	Elementary/Secondary (0-12) College (1-4or 5+)	Rancher			Own Ranch	1
. 12	filed w Hygiei other th	S	17. Father's Name (First, Middle, Last)		. Mother's Name (Fi	st, Middle, Ma		
√ anc	d be fi	Be C	John Jakob Raskob		Helena Sp			
$(\mathcal{O}', \mathcal{I}\mathcal{O})$ Baltimore, Maryland 21215-0036	s 1 and 2 should be filed within 72 ho if Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, it et Medical	To	19a. Informant's Name/Relationship (Type. Print) Regina McCourt Raskob 19b. 4	Mailing Address (Street and 20 Overbrook	Number or Rural Ro Road Balt	imore,	City or Town, State, Zi	o Code) 21212
	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		cemeter	Disposition (Name of y, crematory or other place)	Date		c. Location - City or T	
90	Pages 'nent of the int: If ite		1 Nation 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Valley Memorial (Gar June 2	0,2009	Timonium,	Maryland
alti	permit. Departm Importa any inju		21. Agnature of Funer 15, you Liouviee	22. Name and Address of				
ω_	P S E E G		Nemmes Dycanon (Anagel)				e, Marylar	Approximate
8			23a. Part 1. Enter the disease, or complications that caused the death. Do r shock, or heart failure. List only one cause on each line.	not enter the mode of dying,	such as cardiac or re	spiratory arres	t,	Interval Between Onset and Death
2	Physician		Immediate Cause (Final disease or condition resulting in death)	ze is che	mue CA	deom	10 polly	year
9	/Medical Examiner		Due to (or as a consequence of	of):				<i>U</i>
1		i.	Sequentially list conditions,	of)·				
2 V	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					
3 K	ficate be executed physician and s the burial-transit		resulting in death) Last Due to (or as a consequence of	of):				
0928	ate be nysicia ne bur	dical	d					
1 89	± 5.40	Med	IF FEMALE:					
DM D. Box	w requires that the death certific been signed by the attending p should be detached for use as i	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of deli Month	very Day Year
7	hat the	Phy	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given	in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ds,	signe	d by	desbetes millitus, D	ementer,	<u>. </u>	1 □ Yes	; 2 1 No 3 □ Pr	obably 4 ☐ Unknown
BE	2 10	Completed by	chonic Kidney disea	zi ,		24a. Was an autopsy perform	ed? prior to death?	topsy findings available completion of cause of
$\omega_{\overline{\mu}}^{a}$						1 □ Yes 2	⊒fNo 1 □ Yes	2 🗆 No
Vit.	Physician: The lav this certificate has ral director, page 2	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Other	26. Place of Death (C	_	nce 6 Other (Spe	Hossice
77.2	Phys rr this eral dii	5	27 Mannes of Death 28a, Date of Injury 28b.	Time of 28c. Injury a			v injury occurred	(()
2 6	Attending r death. ector: After by the fune	tior	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation		s 2 No			
RA	or Atter after dea Director	Certification: T	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office	281	Location (Str. City or Town,	eet and Number or Ro State)	ural Route Number,
1/2	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledg 2 Medical Examiner: On the basis of examination a and manner stated.	e, death occurred at the time nd/or investigation, in my opi	e, date and place, an nion, death occurred	d due to the ca at the time, da	ause(s) and manner a ate and place, and due	s stated. e to the cause(s)
り	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License	number	29	d. Date signed (Mont	h, Day, Year)
	F > F 0		1/ Anthy hely and	025	205	Jo	une 17, .	×009
	,		30. Name and address of person who completed cause of death (Item 23a) 1. Date filed (Month, Day, Year) 31. Date filed (Month, Day, Year)	(Type, Print)	of the m	17:30	<u>c</u>	
_			W.A.R. Ly GBMC 6701 N.	Charles Si t	700000	200		
	St Regist	ate rar	31. Date filed (Month, Day, Year) JUN 18 2009 32. Registrar's Signature	and				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 06 **Physician** RUTH 5:14 AM SCOTT 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAMARITAN BALTLMORE (100D If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min. 1 M M F 03/16/1957 52 Director Maryland 216-76-2933 Usual Residence of Decedent la or 28a-f show the notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No **Funeral Director** Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number al Hygiene. other than "naturel", or items 23a ovent, the Mydical Exercitors must be 21206 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hyglene. Importent: If Item 27 is merked other than "naturel", or items 23a any Injury or other treumatic event, the "waldcal Extra internationse. 5002 Raintree Way Apt. K 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black. White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2▼ No ģ Specify Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator Tool and Die 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **Ernest Leroy Carter** Sallie Rogers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 408 Colleen Road Apt. C, Baltimore, Maryland 21229 to of Disposition (Name of Date 20c. Location - City or Town, State Farnestine Carter / Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cemetery 06/22/2009 Lansdowne, Maryland 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 21. Signature of Funeral Service License 4611 Park Hgts, Ave., Baltimore, Maryland 21215 23a. Part 1. Enter the disease, or complications that > used the shock, or heart failure. List only one cause on each line. sused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) SEVERE **Physician** /Medical Due to (or es a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inlitated events resulting in death) Last Due to (or as a consequence of) Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physiclan a s the burial-1 Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant et time of deeth 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months? Month Day Year 1 ☐Yes 2 ☐ No 9 Ulnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 3 Probably 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☑ No 21**/2** No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ves 2 No Medical Certification: To After this 27. Manne eath Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending 1 □Yes 2 □No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

5601 Loch Raver 18

JUN 18 2000

30. Name and address of person who completed cause of peath (Item 23a) (Type, Print)

well

Baltimore, MO 32. Pegistrar's Signature

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ANDALEER

ABRAR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^D2009 **Physician** June 12, 7:18 A Glenn O. Smith /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore Harbor Hospital 8. Date of Birth (Month, Day, Yea Mar. 8, 1 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 68 1942 Maryland 219-40-7971 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 23a or 28a-f show the Medical Exeminer must be notified at Yes 2 No Director N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3003 Janice Avenue 21230 United States permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Modical Eventher rust I once. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1XYes 2 No Unk Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No White Specify. If Yes, Give Year or Dates: 1965 Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Route Sales Air Quality 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Smith Sarah Lavina Millens ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3003 Janice Avenue, Baltimore, MD 21230 Mary Ann Smith - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cemetery 6-17-2009 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Baltimore, MD 4 ☐ Donation Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. Signatule of Funer + Cervice License 1328 Sulphur Spring Road, Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Drono /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ■ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes this After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 27, Manner of Death Natural 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐No death. 2 Accident Director: 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide the Hospital 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Society Tevickos 120 N. Willy RD Banks MD H278

31. Date filed (Month, Day Year) 00 (32. Registrar's Signature factor)

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death [□]2009 **Physician** June 15, 9:30 Рм Carolyn M. Silvania /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 414 Paradise Road Aberdeen Harford 8. Date of Birth (Month, Day, Year) 1923 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 🏌 □ F Hours Maryland 85 Yrs 216-18-0014 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City. Town or Location 10d. Inside City Limits r items 23a or 28a-f show ingreement or confined at 1 ☐ Yes 🙀 No Funeral Director MD Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 414 Paradise Road 21001 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates traumatic event, the Medical Exaþ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Joseph Soistman, Sr. Carolyn Revelle ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Crawford - Daughter 414 Paradise Road, Aberdeen, MD 21001 permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery | 6-19-2009 Baltimore, MD 22. Name and Address of Facility 1328 Sulphur Spring Rd, Arbutus, MD 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Por in the past 12 months?
1 Yes 2 No Month Year Day 4 Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2√2 No 24a. Was an certificate 1 ☐Yes 2 ☐No 21/2/No r this certifice ral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Statement 6 Other (Specify) မ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

within 24 hours aft

To the Funeral Di

completely filled in

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

hand

JUN 18 2009

30. Name and address of person who con

DHMH 17 Rev 1/2001

and manner stated.

ed cause of death (Item 23a) (Type, Print

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene20001 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009 **Physician** une Elizabeth Schneider /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Baltimore Washington Medical Center Glen Burnie If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) ^{Year} 1916 **Funeral** Days Hours Min. Maryland 92 213-10-2541 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercities rough be notified at once. 1 ☐ Yes 2 ▼ No Funeral Director Pasadena Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21122 8004 Shadow Oak Lane 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Specify: White 1 □Yes 2X No Specify: Baltimore, Maryland 21215-0036 þ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Minnie V. Doran Charles H. Schmidl မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type. Print) 11213 Suncrest Drive, Huntsville, AL Denny Schneider - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Uonatipn 5 ☐ Other (Specify) 3 Removal from State Loudon /Park Cemetery 6-18-2009 Baltimore, MD 4 □ tonatton 22. Name and Address of Facility Ambrose Funeral Home, Inc. f Juneral Service Lio ign 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one causes each line. Approximate Interval Between Onset and Death Immediate Cause (Final neumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Atrial Fibrillation **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐Yes 2 ☐ No 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗖 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No 24a. Was an 2 No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) å Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 ☐ Yes 2 000 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. M. n. er of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

JUN 18 2009

32. Registrar's Signature

son who completed cause of

Elizabeth

Schneider

death (Item 23a) (Type Prigit) of tel Drive, Glan Burnie, 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Year 11, June 11:30 PM PATRICIA LORETTA SMITH 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Washington Med Ctr Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Days 1 □ M 2 1 F Maryland 05/02/1939 216-36-1055 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐Yes 2 TNo Pasadena Anne Arundel MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 21122 U.S.A. 114 Kenwood Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes 2 🗹 No 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify. Specify: 3 ₩idowed 4 Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Financial Bookkeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nellie Artes William E. Grose 19a. Informant's Name/Relationship (Type. Print) Pers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 114 Kenwood Road, Pasadena, MD 21122 Robert J. Smith, Sr./Rep 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 06/17/09 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cem 21. Signature of Funeral Swice Licensee 22. Name and Address of Facility G.J.Gonce Funeral Home, PA 169 Riviera Drive, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Myocardial Infarction disease or condition resulting in death) Due to (or as a consequence of): Hypertension Sequentially list conditions, if any, leading to infine diatocause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Juli to (or as a nanenquence of) Coronary Artery Disease Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Diabetes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

Physician /Medical Examiner Examiner

Department of I Important: If ite any Injury or of once.

Physician

/Medical

Examiner

Funeral

Director

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ral", or items 23a or 28a-f shor Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or ury or other traumatic event, Its Marical Examination must be re-

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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Hospital or Attending Physiclan: The law requires that the death certificate be executed sician and burial-trans attending physician for use as the buria signed by the a certificate has birector, page 2 s director, this after death

Director:

Physician/Medical

ş

Completed

Be

Certification: To

Medical

Division of Vital Records, P.O. Box 68760

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

1 Yes 2 No 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) Injury Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

06/12/2009

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the dates(s) and manner stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

D53462

ddress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and

JUN 1 8 2009

7845 Oakwood Road, Glen Burnie, MD 21061 MD, Muneses, 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

within 24 hours aft To the Funeral Di completely filled in

the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Time of Death Decedent's Name (First, Middle, Last) Day **Physician** 245 AM eit 6 2009)une reorge /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Burtonsville Cross Sanctuary at Holy If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year May 12, 1922 7. Age (In yrs. last birthday 5. Social Security Number **Funeral** New York Months 1 M 2 □ F 87 073-14-2794 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ~ ''' and injury or other traumatic event. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ▼ No Director Columbia Maryland Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21045 6150 Forty Winks Way Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Tyyes 2 No If Yes, Give Year or Dates: Anny 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify. þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Lawyer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jane Monahan Frederick Seitz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Columbia, Maryland 21045 6150 Forty Winks Way Barbara Seitz (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Sykesville, Maryland 4 □ Donation 5 □ Other (Specify) Lakeview Memorial Park 6-11-2009 21. Signature of uneral Service Licer 22 Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Co Columbia, Maryland 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Jepsis Physician /Medical Due to (or as a consequence of): **Examiner** Multiple De Dembitus alcors Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical for use as the l IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Linknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 😿 No page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Commary certificate has autopsy performed 2**K** No funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA ဥ After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated.

State Registrar

JUN 18 2009 DHMH 17 Rev 1/2001

29b. Signatu

e and title of certific

31. Date filed (Month, Day, Year)

30. Name and address of pers in who completed cause of death (Item 23a) (Type, Print)

25 Main 2. Registrar's Signature

29c. License number

D0023337

29d. Date signed (Month, Day, Year)

Suite 200 Reisterstown, Mcl 21136

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#31perDVR, G892,6/18/09, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Drew Yeer Month 10.00 AM **Physician** 200 /Medical 4b. City, Town, or Location of Death County of Death Facility Name (If not institution, give street and number, **Examiner** ward Co arc Jen HOSA DIQ O Cent cem If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7, Age (In yrs. last birthday) **Funeral** , 12,1924 Soviet Union Months Days Hours M 2□ F February 85 Yrs 028-38-1494 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show odical Examiner must be notified at 1 ☐ Yes 2 X No Director Clarksville Maryland Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21029 5510 Smallwood Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify Specify: Completed by White 3 ♥ Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Healthcare Cabinet Maker traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elena Kuznitsov Simon Suchorebrow ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health a Important: if Item 27 Is any Injury or other trau once. 5510 Smallwood Court Clarksville, Maryland 21029 Victor Suchorebrow (Son) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6-11-2009 Atlantic Crematory Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Witzke Funeral Homes, Inc 5555 Twin Knolls Road Co 21. Signature of Funeral Service Licenses Columbia, Maryland 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 0 disease or condition resulting in death) O /Medical Due to (or as a consequence of) Examiner ra U as Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of) ner To the Hospital or Attending Physician: The law requires that the death certificate be executed Exami cate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the ceuse of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Records, \$ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No this certificate ı∐Yes Division of Vital director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nnpatient 2 ER/Outpatient 3 DOA 1∐Yes Certification: To funeral 27. Manner of Peath 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? After Injury 5 ☐ Pending investigation Natural thin 24 hours aner continued to the Funeral Director: Af М 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only 29d. Date signed (Month, Day, 29c. License number 29b. Signature and title of certifier 2 22 30. Name and address of person who completed cause of CeKHF 8 E 32. Registrar's Signature
JUN 18 2009 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For Amend Item 29d 1-State Registrar	State of Marylon	9 06)998 Cei	yoganb of l rtificate of	Health and <i>Death</i>	d Mental Hy	giene Reg. No. 200	9 19617
	Physici /Medic		1. Decedent's Name (First, Middle, Last) RICHARD		ACKERM			2. Date of De JUNE	05 ^{Day} 2009 ^e	
	Examin	er	4a. Facility Name (If not institution, give s 6208 HILLTOP AVEN 5. Social Security Number 6. Sex	UE	a at thirth days	4b. City, Town, o	TIMORE If Under 24 H			eath //A Birthplace (State or Foreign
	Funeral Director		080-18-5960 Usual Residence of Decedent 10a. State 10b. County	M 2□F 86	Yrs.	Months Days		in. 01/31	71923	NJ 10d. Inside City Limits 10d/Yes 2 No
	be filed within 72 hours after death with the Maryland ital Hygiene. sd other than "natural", or items 23a or 28a-f show event, the Medical Exa-driver must be recified at	Funeral Director	112 Marita Otatao	12. Was Decedent Ever in U.S			206 Hispanic Origin? an, Mexican, Pu	(Specify Yes or No	10g. Citizen of What USA 14. Race - A Black, W	,,
21215-0036	within 72 hours afte iene. than "natural", or I	Completed by F	1 Management 1 Married 2 Married 3 Married 3 Midowed 4 Divorced 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12	1 MYes 2 □ No If Yes, Give Year or Dates: cation c completed) College (1-4or 5+)	16a. Dece (Give life.	1 □ Yes 2 No dent's Usual Occup kind of work done DO NOT use retire ARTOGRAP	oation during most of v d)	working	Specify: 16b. Kind of Busine RAILR(ess/Industry
land 2	ld be filed lental Hygi ked other ic event, li	To Be Co	17. Father's Name (First, Middle, Last) MILTON	SACKERMAN		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	18. Mother's N	lame (First, Middle	, Maiden Surname)	
, Maryland	ges 1 and 2 should be tt of Health and Mental If item 27 Is marked or or other traumatic ev		19a. Informant's Name/Relationship (Ty) DOROTHY SACKERMAN/S	pe. Print)				Rural Route Numb	ver, City or Town, Star	te, Zip Code) 07647
Baltimore,	Pages 1 and of He unt: If item		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X R 4 ☐ Donation 5 ☐ Other (Specify)	C	emetery, cher	esition (Name of matory or other pla ER HILLS	ČEM 06/	Date /12/2009	20c. Location - City HASTINGS-	or Town, State ON-HUDSON, NY
Balt	permit. Pag Department Important: I any Injury o once.		21. Signature of Funeral Service License	attle	ess of Facility STERSTO		NSON & BRO	E, MD 21208		
8760,	Physician / / / / / / / / / / / / / / / / / / /	dical Examiner	23a. Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, Lading to finite order to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence).	FIC /			RC/WOM		Approximate Interval Between Onset and Death
O. Box 6	atth certifi attending for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d	death 3	☐ Ectopic pregnan ☐ Other (specify)	су		23d_Date of Month	f delivery Day Year
rds, P.	law requires that the de as been signed by the 2 should be detached	d by Ph	Part II. Other significant conditions cor	ntributing to death but not resu	ulting in the u	nderlying cause gi	ven in Part I.	111		te to the cause of death? Probably 4 Unknown
Division of Vital Records,	: The law rec cate has bee page 2 shou	Completed						24a. Was auto perfo 1 □ Yes	ppsy prior deat	e autopsy findings available r to completion of cause of th? Yes 2 □No
Vita	Physician: The tribic certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 DOA Ott	nor:	Death (Check only	one) idence 6 ☐ Other (Specify)
ion of	Ing After une	Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time o Injury	f 28c. Inju	iry at	<u> </u>	how injury occurred	5,250,7
Divis	tal or Attend s after death al Director: / ed in by the f	Certific	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	reet, factory, office		28f. Location (City or To	(Street and Number own, State)	or Rural Route Number,
)	ie Hospital 24 hours a ie Funeral I	Medical	29a. Certifier (Check only one) 11 CertifyIng Physical Control Contro	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, deat tion and/or in	th occurred at the to extigation, in my	ime, date and popinion, death of	lace, and due to the occurred at the time	e cause(s) and mann , date and place, and	er as stated. due to the cause(s)
	To the within 2 To the complex	Me	29b. Signature and title of certifier	MD		29c. Licen	1/0619		June 5	7777
_			30. Name and address of person who co		23a) (Type,	Print)	ARE DR	NOTTI	NOHAM, MA	D. 21236
E	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	park					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 7:45 A. M David Thomas Saffran 2009 June 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A 1324 Washington Blvd. Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1**⊠** M 2□ F 68 Maryland 217 38 9077 05/13/1941 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State d other than "natural", or items 23a or 28a-f show event, the Medical Examinations to multifud at 1 ☐ Yes 2 ☐ No Director N/A Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1324 Washington Blvd. 21230 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 西 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: 2 White 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, It always Elementary/Secondary (0-12) College (1-4or 5+) Balto. City Schools Maintenance Worker 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph W. Saffran Sr. Mary A. Smith 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) James Sigafoose 2047 Whistler Avenue Baltimore, Maryland 21230 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 A Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 06/16/2009 Baltimore, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gonce Funeral Service, P.A. nominous 4001_Ritchie Highway Baltimore, Maryland 21225 23a. P v1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 5 yeu /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any sealing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): attending physician Physician/Medical nse If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy For Month in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 12 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 1 ☐Yes 2 ☐No 1 Tyes completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deatl Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

121

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) JUN 18 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month **Physician** 2000 Simpson Alice 15 June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Columbia Howard County General Hospital Birthplace (State or Foreign Country)
 D 8. Date of Birth June 24, 1926 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Months Days Min Hours 1 □ M 2 🖫 F 82 212-20-1598 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show 1 ☐ Yes 2 No "natural", or items 23a or 28a-f shovedical Examiner must be notified at Dayton MD Howard Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21036 5232 Greenbridge Road by Funeral death 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) alth and Mental Hygiene. 27 is marked other than " r traumatic event, the Mer Elementary/Secondary (0-12) College (1-4or 5+) Domestic Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Viola Suffornina Green Walter Gary Whitehead 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 shr Department of Health and Important: If item 27 is m any injury or other traum: once. 1749 Arrington Road Marriottsville, MD 21104 Mr. Harry Simpson 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Sykesville, MD All County Cremation 6/19/2009 4 ☐ Donation 5 ☐ Other (Specify) ²²HATGHT FUNERAL HOME & CHAPEL, P.A. 21. Signature of Funeral Service Licenses Hugh M00X4 PO BOX 195 Sykesville, MD 21784 ∞ , 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final da **Physician** peritonitis disease or condition resulting in death) /Medical Die to (or as a consequence of): **Examiner** bowe forated Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to (or as a consequence of): Examine or Attending Physician; The law requires that the death certificate be executed cholein Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) the 9 I Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division or Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Preumonia Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2410 2 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊈Inpatient 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3□ DOA Certification: To this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After t (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident death. 24 hours after death e Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical

Registrar

State

To the within 2

31. Date filed (Month, Day, Year) DHMH 17 Rev 1/2001

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

120066515

29d. Date signed (Month, Day, Year)

15

2009

2104

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend #2,385aRer Maxia For 1882 and 1880 Health and Mental Hygiene

		•	1 - State Registrar	•	rtificate of L		Re	a. No. 2 1	09 19620
П	Physicia	an	Decedent's Name (First, Middle, Last) LUBA	SIEKI	IEDKV		2. Date of Death	June 14 15 20	,2009. Time of Death ear 6:30 pm
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	SILKI	4b. City, Town, or	Location of Death	OONE	4c. County of	Death
t			130 SLADE AVENUE, #621 529344600055 6. Sex 7. Age (In	yrs. last birthday)	BALTIM If Under 1 Year	ORE		9	BALTIMORE D. Birthplace (State or Foreign
ı	Funeral Director	-	587-35-7041 1□M 21XF	83 Yrs.	Months Days	Hours Min.	04/15/	1926	POLAND POLAND
	/land		Usual Residence of Decedent 10a. State 10b. County 10c	c. City, Town or Loc	cation				10d. Inside City Limits
	e Mary 8a-f sh diffect	Director	MD BALTIMORE		BALTI	MORE	1.		1 Yes 2 No
	with th	I Dire	10e. Street and Number 130 SLADE AVENUE, #621		10f. Zip Code	1208	11	0g. Citizen of Wh	at Country?
	be filed within 72 hours after death with the Maryland that Hyglene. dother than "natural", or items 23a or 28a-f show event, it a fledical Examination in afficial at	Funeral	11. Marital Status 12. Was Decedent Ever Armed Forces?	in U.S. 13. V	Was Decedent of H		pecify Yes or No- Rican, etc.)		American Indian, White, etc.
920	urs afte	ρ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	1 □Yes 2 💢 No	Specify:		Specify:	WHITE
Maryland 21215-0036	72 hou "natura	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done	durina most of work		16b. Kind of Busin	
2121	l within giene. r than	ошо	Elementary/Secondary (0-12) College (1-4or 5+)	IIIe. L	DO NOT use retired SEAM	STRESS		GARMEN	Т
nd	e d dal	Be	17. Father's Name (First, Middle, Last)	DADADOI).T		e (First, Middle, M		LASKA
aryla	should be tnd Mental marked c	မှ	SAM 19a. Informant's Name/Relationship (Type. Print)	RAPAPOF	ng Address (Street	ANNA and Number or Ru	ral Route Number	The Real Property lives and the Control of the Cont	
Š,	s 1 and 2 should of Health and Men Item 27 is marke other traumatic		NATHAN SIEKIERKA / SON					_S CHURC	H, VA. 22043
Baltimore,	Pages 1 nent of h int: If Ite		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Ob. Place of Dispos ANSHEEDEMI ATT CHAI	isition (Name or natoring other place IM CONG.	e) 06/16		BALTIMOR	
altii	permit. Pages Department of Important: If II any injury or once.		21. Signature of Funeral Service Licensee	22	2. Name and Addres	ss of Facility S	LEVINS	SON & BR	OS., INC.
	20 E # 0		23a. Part1. Enter the disease, or complications that caused the						LE, MD 21208 Approximate Interval Between
	Physician		shock, or heart failure. List only one cause on each line.	Varia	0	hcer			Onset and Death
	/Medical Examiner		resulting in death) a. Due to (or as a con						
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin. Cause (Disease or injury that initiated events	nsequence of):					
	xecuted and I-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last C	nsequence of):					
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Aedical E	d						
89 x	certifica ding ph	/Med	IF FEMALE: 23c. If yes, outcome of pr	regnancy				22d Data	of delivery
O. Box	at the death cert I by the attending stached for use a	Physician/N	23b. Was decedent pregnant in the past 12 months? 1	Fetal death 3 [☐ Ectopic pregnand ☐ Other (specify) _	у		Mont	
P.	that the		9 Unknown Part II. Other significent conditions contributing to death but no	t resulting in the ur	nderlying cause giv	en in Part I.	23e. Did tol	bacco use contrib	oute to the cause of death?
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Ž	Sir d	To Be	examiner?	2 ☐ ER/Outpatier		er: 4 ☐ Nursing H			(Specify)
ono	ding P h. After t funera	tion:	27. Manner of Death 1 Natural 5 Pending (Month, Day, Ye. 2 Accident investigation	ar) 28b. Time of Injury	Wor	ryat k? Yes 2 ∐No	28d. Describe ho	ow injury occurred	d
Division of Vital	r Atten er deat rector: by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - building, etc. (S	At home, farm, str pecify)	reet, factory, office		28f. Location (S: City or Town		r or Rural Route Number,
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 12 Certifying Physician: To the best of m	y knowledge, deat	th occurred at the ti	me, date and place	and due to the o	cause(s) and mar	nner as stated.
	the Hos iin 24 h ihe Fur ipletely	Medical	(Check only 2 Medicel Examiner: On the basis of examiner) and manner stated.	mination and/or in	vestigation, in my	opinion, death occu	irred at the time, o	date and place, ar	nd due to the ceuse(s)
•	Voirt Con	Σ	29b. Signature and title of certifier		29c. Licens	se number		-	(Month, Day, Year)
	101		J	(Item 23a) (Type,	D : 1)				
	10 ,		Howard Sajont 2 23 (31. Date filed (Month, Day, Year) 32. Registrar's 5	Signature	eds Dn	. Jte +	340	wings !	M:112 Md. 21117
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		-	For State Registrar	State of Mary	riaric	•	rtificate of			Reg. No.	2009	1962
	Physicia		1. Decedent's Name (First, Middle	e, Last)		CTE	TAULODA		2. Date of Dea Month	ath Day	Žear 2009	3. Time of Death
1000	/Medic	al	LILLIE 4a. Facility Name (If not institution	n aire street and number)		SIE	I NHORN	r Location of Death	JUNE		County of Death	
	Examin	er	GILCHRIST HOSP				TOWSON					BALTIMORE
	Funeral Director		5. Social Security Number 219-42-6222	6. Sex 7. Age (No. 1	98 98	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 05/26/	1911	9. Birth Cou	place (State or Foreign intry) MD
	land ow		Usual Residence of Decedent 10a. State 10b. County	10	c. City,	Town or Lo	cation					10d. Inside City Limits
	the Marylan 28a-f show	ctor	MD	BALTIMORE	OWI	NGS M	ILLS					1 ☐ Yes 2 💢 No
	with the	Funeral Director	10e. Street and Number	UDT #267			10f. Zip Code	21117		10g. Cit	tizen of What Cou	untry? USA
	ms 23	neral	4730 ATRIUM CO	12. Was Decedent Eve	r in U.S	3. 13.		Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No)-	14. Race - Amer	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Eventiner must be notified at	ρ	1 XNever Married 2 Mar 3 Widowed 4 Divorced	If Yes Give			1 □Yes 2 💢 No	Specify:	nican, etc.)			ITE
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212	withir giene. r than	dmo;	Elementary/Secondary (0-12)	College (1-4or 5+)		1110.		STATISTI		SOCI	AL SECUE	RITY ADMIN.
	be filed value tal Hygid doubler	Be C	17. Father's Name (First, Middle,	Last)	C7	FF TAILLO	DN	18. Mother's Name		, <i>Maid</i> er		KLER
Maryland	12 should be filed th and Mental Hyg 7 is marked othe traumatic event,	은	SAMUEL 19a. Informant's Name/Relations	ship (Type, Print)	51	TEINHO	ng Address (Street	and Number or Rur	al Route Numb	er, City	or Town, State, Z	(ip Code)
, Ma	and 2 sealth ar		LARRY LA SOV /	NEPHEW		205 G	LYNDON M	EADOWS RD	., REIS	TERS	STOWN, MI	21136
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 LI Hemoval from State			osition (Name of matory or other pla		7 / 2 0 0 0		ocation - City or T	
ıltir	nit. Pa artmer ortant injury e.		21. Signature of Puneral Services		HEE	2	RIENDSHI 2. Name and Addre	ess of Facility S	7/2009] OL LEVI	NSON	& BROS	., INC.
Ba	Dep Imp any		1 Talut	7 . James							KESVILLE	, MD 21208
			23a. Part 1. Enter the disease, o shock, or heart failure. Lis	r complications that caused the ronly one cause on each line.	e death	. Do not en	ter the mode of dy	ing, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
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ما	ted sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	onsequ	ence of):						
179	rtificate be executed ng physician and as the burial-transit		that initiated events resulting in death) Last	c Due to (or as a c	onsequ	ence of):						
, 68760,	ate be physicia the bu	Medical		d								
-	as as	/Mec	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of							23d. Date of del	ivery
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	iding Physician: th. After this certifical funeral director, p	on: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pendi	28a. Date of Injury		28b. Time o	of 28c. Inju	ury at ork?	28d. Describe			
Division	ttendii Jeath. tor: A	icatio	2 Accident invest	igation	- At ho	me farm st]Yes 2□No	28f Location	(Street a	and Number or Ri	ural Route Number,
Div	al or A s after I Direct	Certification:	4 ☐ Homicide deter	28e. Place of Injury building, etc. ((Specif)	()	, 550, 145, 61, 51, 51, 150		City or To			
	To the Hospital or Attending Physician: The law requires that the death oe within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendit completely filled in by the funeral director, page 2 should be detached for use	Medical C	29a. Certifier (Check only one) Certify Certify Certify	ing Physician: To the best of a I Examiner: On the basis of ea and manner state	vamina	tion and/or i	proctigation in my	opinion doath occu	rrad at the time	e oteh e	nd place, and due	s stated. e to the cause(s)
	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completely filled in by the fur	Mec	29b. Signature and title of certifi				29c. Licer	ise number 5830 NAVIS ST	3	29d. D	Pate signed (Mont	h, Day, Year)
	8		30. Name and address of person		th (Item	1 23a) (Type	, Print)	napola Cit	Din	00	NO	,
	Sta		31. Date filed (Month, Day, Year	y 31. Registrar's	s Signa	ture	10 0		10,00			
	Registi	rar	JUN 18	2009 Persona	B	. 430	a Kee					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Baby Boy Tobias	1- For State Registrar	tate of Maryland	d / Department Certificate		nd Mental I		eg. No.	2009	9 1962
Physician/ Medical Examiner	1. Decedent's Name (First, Midd Baby Boy Tobia					2. Date of Dea Month June 4, 20	Day `	Year 3	3. Time of Death 1530 hrs
()	4a. Facility Name (if not institution Prince George's Hos	. •	er)	4b. City, Town, Cheverly	or Location of Dea	ath		ty of Death George's	3
Funeral Director	5. Social Security Number None	6. Sex 7. / 1 XM 2 F	Age (In yrs. last birthday)		ays Hours M	lin.	th(MM/DD/YY	Foreign	place (State or
Any	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation					10d. Inside City Limits
	MD Princ	e Georges	Bowie						1 X Yes 2 No
the Maryland or 28a-f sh iified at once	10e. Street and Number	- L T //201		10f. Zip Code		1	0g. Citizen of	What Countr	y?
with the us 23n o	4011 Elm Cres 11. Marital Status	12. Was Decede	ent Ever in U.S. 13.	2071 Was Decedent of I	Hispanic Origin? (Specify Yes or No			an Indian, Black,
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygene. trant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatle event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		Armed Force 1 Yes vorced If Yes, Give Year or Dates:	9S? 2 X No	If Yes, specify Cub		rto Rican, etc.)		hite, etc. _{fy:} B1ac	:k
5-0036 ed within 72 hours afti itygiene. other than "natural" the Medical Examine Completed by	15. Decedent's Education (Spe Elementary/Secondary (0-12)	scify only highest grade c	during	dent's Usual Occup g most of working I			16b. Kind of	Business/Ind	dustry
within within in the care than Medical	0		No	ne	Landa III day	(E' at Middle	No		
MD 21215-0036 nd 2 should be filed within 7 ath and Mental Hygiene. m 27 is marked other than aumatic event, the Medical To Be Comple.	17. Father's Name (First, Middle Timothy Sean	•				me (First, Middle, N. Tobia		me)	
212 hould be and Ment is mark	19a. Informant's Name/Relation			iling Address (St	reet and Number of	or Rural Route Nu	mber, City or 1		Zip Code)
, MD and 2 st ealth an em 27 i	Timothy Sean 20a. Method of Disposition	Black/Fathe		1 Elm Cr		#201 B		D 207 on - City or T	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene Important: If item 27 is marked other than injury or other traumantie event, the Medical To Be Comple	1 K Burial 2 Crematio	Specify:	State crematory of Marylan	rother place) id Nation	al 6/	20/09	Laure	-	
Balt permit Depart Impor	21. Signature of Funeral Service	a Licensee		2. Name and Address 831 Geor					20011
Physician /Medical	23a. Part I. Enter the disease, o failure. List only one cause	e on each line.	ed the death. Do not ente	er the mode of dyir	ng, such as cardia	c or respiratory an	_		Approximate Interval Between Onset and Death
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certificate be nding physici se as the buri	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	the 1 Live birth		Fetal death	3 Ectopic preg	gnancy	23d. Date Mont	e of delivery h Da	ay Year
). Box 6876 the death certificat by the attending phy chef for use as the		9 Unknown		Other (Specify)					
P.O. es that the iigned by be detach	Part II. Other significant cond	tions contributing to de	eath but not resulting in the	ne underlying caus	e given in Part I.			_	ne cause of death? ably 4 Unknown
Division of Vital Records, P.O. Box 6876i pital or Attending Physician: The law requires that the death certificate rours after death. seral Director: After this certificate has been signed by the attending phy filled in by the funeral director, page 2 should be detached for use as the tectrification: To Be Completed by Physician/MA	()						psy ormed?	prior to co death?	opsy findings available ompletion of cause of
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Vital hysician this certi I directo	examiner? 1 Yes 2 No	Hospital: 1 🗸 Inpa	atient 2 ER/Outpati			rsing Home 5	Residence		
n of ding Ph. h. After t funeral	27. Manner of Death 1 Natural 5 Per	28a. Date of I (Month, Da	y,Year)	l	njury at Work? Yes 2X No				of auto tha
isio Atten er deatl rector by the ficati	2 X Accident Inve	estigation 0/4/09	0903 f Injury - At home, farm, s	nrs		collide 28f. Location			al Route Number, City Branch Ave
Division o spital or Attending hours after death. neral Director: Aft y filled in by the fune Certification:	4 Homicide	ermined (Specify) O	ther			SE Was	hingto	n, DC	Diancii Ave
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atte completely filled in by the funeral director, page 2 should be detached for u Medical Certification: To Be Completed by Physic		Physiclan: To the best of aminer:On the basis of e and manner state	xamination and/or invest						
H SH S	29b. Signature and title of certif		MI		ense number C.M.E.		June 5,		th, Day, Year)
	30. Name and address of perso Russell Alexander M			11 Penn Stree	et, Baltimore,	MD 21201			1
State	31. Date filed (Month, Day, Year		trar's Signature	- 10 1	 				
Registra	2011 1 8	2009 Gensi	u 13. 190	was					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Rea. No. 3. Time of Death 2. Date of Death acedent's Name (First, Middle, Last) **Physician** /Medical Town, or Location of Death Facility Name (If not institution, give street and number) County of Death **Examiner** Lament If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Age (In yrs. last birthday) Sex **Funeral** Hours Months Days 1₽M 2□F Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location State 10h. County fshow ir than "natural", or items 23a or 28a-f show the Wedical Evantiner must be notified at 1 Nes 2 No Director more 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe HVENLLE Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Manay Injury or other traumatic event, the Manay Injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be lay ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Frint) (\$1.\$+27) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) . Method of Disposition 1 MBurial 2 ☐ Cremation 3 Removal from State 6/18/ Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final 21216 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or Highly that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physlclan: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760. signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed? Yes 2 \(\sumbox{\text{No}}\) 2 Mo 1 ☐ Yes 1 Yes 2/strept Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Yes 2 No 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation nours after death.

neral Director: At filled in by the fur 1 □Yes 2 □No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 24 hours a Funeral I Certitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical etely within 2 29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of

Name and address of

DHMH 17 Rev 1/2001

ause of death

32. Registrar's

29c. License number

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 15 A M Physician /Medical ution, give street and number) or Location of Death 4c. County of Death Examiner KUHIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year Days 1 ☐ M 2 X F Yrs **Director** Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside/City Limits 10a. State 10b. County 10c. City_Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a findical Exaction is not be useful as 1 ✓ Yes 2 No **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 2 No Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ashiek 18. Mother's Name (First, Middle, Maiden Surname) Be (Father's Name (First, Middle, Last) ൧ 19b. Mailing Address (Street and Number of Rural Route Number, Fity or Town, State, Zip Code) 19a. Informant's Name/ elationship (Type. Print) Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of carnetery, crematory or other place) Date 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Baltimore. 22. Name and Address of Facility 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hor filling. ZIZI Immediate Cause (Final disease or condition resulting in death) **Physician** irrNosis /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed and burial-tran Due to (or as a consequence of) Physician/Medical as Box for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) detached Ö 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ò funeral director, page 2 should be 1 ☐ Yes 2 ☐ No Probably 4 ☐ Unknown per lension Be Completed hompsor 24b. Were autopsy findings available prior to completion of cause of death? rell. To 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 0 No 1 ☐Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ≯DNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 40062554 13. Jive OF

State Registrar 31. Date filed (Month, Day, Year)

Cynthia

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar's Signature

Richar

Hospice

Street

Baltimore, MD 21201

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009 JOSEPH EDWARD UNGER, SR. JUNE 11 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE WASHINGTON MEDICAL ANNE BURNIE GLEN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign . Age (In yrs. last birthday) Months Days 02/06/1945 Maryland 212-44-9966 64 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 ☐ No MD Anne Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21122 U.S.A. 7850 Mayford Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ₩76s 2 □ No 1965 -If Yes, Give Year or Dates: 1967 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 □Yes 2 ▼No Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Police Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Gordon Unger Mary Elizabeth Raysinger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7850 Mayford Avenue, Pasadena, MD 21122 Joyce R. Unger / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from State 06/16/09 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, MD MD Veterans Cem 22. Name and Address of Facility G.J.Gonce Funeral Home, PA 21. Signature of Funeral Solvice Licensee 169 Riviera Drive, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final METASTATIC LUNG CANCER disease or condition resulting in death) Due to (or as a consequence of) PNERMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dusity for as a consequence off Due to (or as a consequence of) IF FEMALE yes, outcome of pregnancy ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 23e Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes

Physician /Medical Examiner

Physician

/Medical

Examiner

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Certification: To

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Director

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Eventure must be netfined at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "amy injury or other traumatic event, the Meanne."

Baltimore, Maryland 21215-0036

Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran P.O. Box 68760, signed by the a Division of Vital Records, cate has been signated by page 2 should b

certificate funeral director, this After 1 Hospital or Attending nours after death.

neral Director: A
filled in by the for within 24 hours a

1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2. No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated.

29b. Signature and title of certifier

JUN 18 2009

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of p erson who completed cause of death (Item 23a) (Type, Print)

TSION 31. Date filed (Month, Day,

32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 6:21 PM THOMAS EDWARD UTZ June 13 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 404 Mathias Court Unit F Carroll Westminster 8. Date of Birth (Month, Day, Year) June 14,1962 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1**∑**M 2□ F Maryland Director 46 218-82-1332 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f shov Examiration must be multified at 1 XYes 2 □ No Director MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 USA 404 Mathias Court Unit F Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2X No Specify. Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Security Guard Security Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be . Pages 1 and 2 should be fil Iment of Health and Mental H Iant: If item 27 is marked oth Ervin Edward Utz ပ Claudette McGhee and I 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Claudette M. Utz/mother 325 Bucher John Rd. Union Bridge, MD 21791 other Department of Heal Important: If item 2 any Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) All County Cremation 6/16/2009 Sykesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hartzler Funeral Home otharine Q. 6 E. Broadway Union Bridge, MD 21791 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Gunshot Woun /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Physician/Medical Examiner Physician: The law requires that the death certificate be executed the burial-tran resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. if yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 Tyes 2 TNo 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∏ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of injury 28d. Describe how injury occurred or Attending 5 Pending investigation 1
Natural 6/13/09 1814 M 1 ☐Yes 2 ☐ No 2 Accident Gunshot to head the Director: 6 ☐ Could not be 3 X Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Westminster filled in by Westminster, MD 404 Mathias Ct Unit Home

P.O. Box 68760, Division of Vital Records, within 24 hours a

Registrar

completely

29a. Certifier

(Check only one)

29b. Signature and title

Medical

31. Date filed (Month, Day, Year) JUN 18 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2973 Manchester Rd Manchester MD 2110 Tr. MA lerson" Registrar's Signature

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Privaction Marrier V. Urie Ac. City Yew, or Location of Death Ac. City Yew, or Location Ac. City Yew, or Location of Death Ac. City Yew, or Location Ac			_	State Registrar	tate of Maryland	•	tificate of L		Re	eg. No. 2	109	19627
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Physician Phys	ryla	hould nd Mer marke matic	입	19a Informant's Name/Belationship (Type.	Print)	19b. Mailin	g Address (Street	and Number or Rui	al Route Number	, City or Town	ı, State, Zi	p Code)
20s. Method of Disposition 21s. Signature of Functal Service Licensee 22s. Name and Address of Facility acz corrows ki Functal Home 1201 Dundalk Avenue Baltimore, Md. 2 23s. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23s. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23s. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23s. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23s. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23s. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23s. Was case or cardial arrest the disease or cardial arrest the disease or cardial arrest the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23d. Date of delivery 24a. Was an autopsy inding general a	⊠	tra tra			,							
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23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Medical Examiner The disease of condition resulting in death) The disease of condition resulting in death or cause of each line. Due to (or as a consequence of): D	<u>m</u>	Page nent c ant: If ury or			oval from State Bay	view	Cremato	ory 6-19				
Physician Medical Examiner Ph	Balt	permit. Departi Imports any Inji once.		21. Signature of Funeral Service Licensee		122	Name and Addre	^{ss of Facili} 校ac 2 dalk Ave	orowsk enue Ba	i Fund ltimo:	eral re,	Home,PA Md. 21222
Image: Cause (Final death) Image: Cause (П			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one c	ons that caused the death	. Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
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Due to (or as a consequence of): Due to (or as a consequence of):		rted nsit	nine	cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ionoc ory.					1	
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C P E C 1 ↑ The Natural 5 □ Pending (Month, Day, Year) Injury Work?	⋚	s certi		examiner?	pital: 1 □ Inpatient 2 □	ER/Outpatier	at 3 🗆 DOA Oth				ther (Spec	city) Hopkus
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29a. Certifier (Check only check only check) 29a. Certifier (Check only check on check on check only check on chec	_	Hospita 4 hours Funeral tely filled		(Check only 2 Medical Examiner	 On the basis of examina 	wledge, deat ition and/or in	h occurred at the to	ime, date and place opinion, death occu	e, and due to the arred at the time,	cause(s) and date and place	manner as e, and due	s stated. to the cause(s)
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1 130 Name and address of person who completed cause of death (fletil 25a) (flybe, Ffiftt)		n ~		30. Name and address of person who comp	oleted cause of death (Iten	n 23a) (Type,	Print) PUS Es		Age B	Bett	NE	21224
State 31. Date filed (Month, Day, Year) 32. Registrar's Signatu		St	ate					- /				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month June 17, 2009 11:55 AM **Physician** Sharon M. Vashaw /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll 4215 Old Hanover Road Westminster 8. Date of Birth (Month, Day, Nov 14, Birthplace (State or Foreign
Country) If Under 1 Year | If Under 24 Hrs. Year) 1947 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** California Months Days Hours 1 □ M 2 🛛 F 556-72-0264 61 Director Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedical Event records be redifficed at once. 1 ☐ Yes 2 No Westminster Director Marvland Carroll 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **USA** 4215 Old Hanover Road 21158 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Financial Administrative Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marv Johnson Jack Vashaw 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4215 Old Hanover Road Westminster, Maryland 21158 Suzann Stein, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/18/09 Baltimore, Maryland Metro Crematory Inc. শৈশারণিপাণ্ডিতিবিশিষ্ট্র Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 21. Signature of Funeral Service Licemsee Thomas Gregor roman 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hodg Kin **Physician** disease or condition resulting in death) /Medical Due to (or as consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician the burial Physician/Medical attending p for use as t IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month in the past 12 months? 5 Other (specify) ☐Yes 2☐No been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Vonknown KHOWH Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 ☐ Yes 2 No 1 ☐ Yes 26. Place of Death (Check only gne) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide determined 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death

To the Funeral Director:
completely filled in by the

Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier, M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street S. Center

Westerinster, Md. 21157 Saiontz 555 Howard

State Registrar 29a. Certifier

32. Registrar's Signature 31. Date filed (Month, Day, Year)

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene / 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 17, 2009 7:10 A M Edna Louise Wallace 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Catonsville Ridgeway Manor Nursing Home 8. Date of Birth (Month, Day Ye If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Year 1929 Months Days Hours Maryland 217-26-0354 79 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location YEJYes 2□No N/A Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21223 United States 510 Hurley Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify: Specify: White 3 X Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Department Store Cashier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edna William Eyring 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1238 Linden Avenue, Arbutus, MD 21227 19a. Informant's Name/Relationship (Type. Print) Stewart J. Wallace - Son 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ☐ Burial 2 X Cremation 3 ☐ Removal from State 6-20-2009 Atlantic Crematory Glen Burnie, Maryland 4 Donation 5 ☐ Other (Specify) Countre Funoral Service License 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTASIS TIPLE 2 months BRAIN disease or condition resulting in death) Due to (or as a consequence of): CARCINOMA OF LUNG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ESSENTIAL HYPERTENSION PAROXYSMAL 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of FIRRILLATION, DEEP VEIN THROMROSIC 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No 1 ☐Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

iral", or items 23a or 28a-f show Examiner must be notified at

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nt of Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, Item M

permit. Pages 1
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Important: If itel
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Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

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Funeral

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the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-tran attending physician for use as the buria been signed by the should be detached rector, page 2 s : After this certific tuneral director, p after death.

I Director: Af
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Division of Vital Records, P.O. Box 68760,

Examiner Physician/Medical <u>გ</u> Completed Be Certification: To 27. Manner of Death 1 X Natural 2 Accident 3 ☐ Suicide 4 Homicide

29a Certifier

23b. Was decedent pregnant in the past 12 months? 1 ☐Yes 2 No 9 Unknown

IN LEGS

5 ☐ Pending investigation

6 ☐ Could not be determined

and manner stated. 29b. Signature and title of certifier anal le Ran

28a. Date of Injury (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , 3455 Wilkens Ave. Suite L10., Baltimore, Mol2129

M.D.

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Komal K. Dang 31. Date filed (Month, Day, Year)

JUN 18 2009

32. Registrar's Signature

within 24 hours after

To the Funeral Dire

completely filled in b

Medical

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 14 **Physician** Year 2009 June Carl Waldecker Jr. 05:45 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8106 Frances Lane Pasadena Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Months 1 M 2 □ F Days Hours 212-26-9626 80 Director Jan. Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Exeminar must be notified at Director 1 □Yes 2 □ No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 8106 Frances Lane Funeral 21122 USA or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after intent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or ite 1 ☐ Never Married 2 ☑ Married 1 ☐Yes 2 ☑ No Specify. White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed \$5. Decedent's Education (Specify only highest grade comp 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Inspector BGE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be C. William Waldecker Sr. ပ Freida Wolf 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances E. Waldecker (spouse) 8106 Frances Lane, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June 18 permit. Pages
Department of
Important: If it
any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Cemetery 2009 Elkridge, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Par 1. Enter the disease, or a mplications that caused the sinck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Myocara /Medical Due (or as a consequence of): Examiner Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Date to for as a consequence of) the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No

or Attending Physician; The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records,

Baltimore, Maryland 21215-0036

After

Certification: To

Medical

State

Registrar

s after decral Director; Atte filled in by To the Hospital of within 24 hours af To the Funeral Discompletely filled in

2 Accident

(Check only one)

29a. Certifier

3 Suicide 4 Homicide

investigation 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

100

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 78450 Acwood 20 swite

31. Date filed (Month, Day, Year)

JUN 18 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 3:05 2009 Betty H. White UNE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ANNE ARUNDEL BURNIE GLEN BALTIMORE WASHINGTON MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day Year) 04/09/1933 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🖾 F 76 Maryland 215 30 5549 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Wedical Examiner must be notified at 1 ☐ Yes 2 K No Director Severna Park Anne Arundel Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21146 482 White Cedar Lane Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2 🔼 No Specify. Specify: ģ White 3 → Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) Hygiene. Elementary/Secondary (0-12) Administrative Assistant Real Estate Company years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel Skrenchuk ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21227 Department of Health of Important: If item 27 is any injury or other tra 3017 Vermont Avenue Tina Flinchum / Friend 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 1 🖾 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 06/12/2009 Holy Cross Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 raminousk 23a. Part 1. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Immediate Cause (Final PNEUMONIA Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner FAILURE RESPIRATORY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit FAILURE RENAL be execute and Due to (or as a consequence of): attending physician EP51 Physician/Medical the as IF FEMALE: for use a 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 No 4 Pregnant 5 Other (specify) Pregnant at time of death the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown BLEEDING TINAI been si should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe this certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 \sum Nursing Home 5 \sum Residence 6 \subseteq Other (Specify) 1 Yes 2 No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending Pl
 hours after death.
 Funeral Director: After the 28c. Injury at Work? After t 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my original death occurred. 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and till of certifier D0061832

State Registrar 31. Date filed (Month, Day, Year)

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DHMH 17 Rev 1/2001

Maryland 21215-0036

Baltimore,

Box 68760

P.0.

Division of Vital Records,

301

32. Registrar's Signature

HOSPITAL DRIVE GLEN BURNE 21061

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12 V

Michael R.

31. Date filed (Month, Day, Year)

Michael

JUN 18 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Grunwald

32 pegistrar's Signature

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Registrar

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2009

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Physician 1208 PM 2009 JUNE NAWATHA VIVIAN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner COLUMBIA If Under 1 Year | If Under HOWARD COUNTY GENERAL ber 6./Sex 7. Age HOSPITAL HOWARD 8. Date of Birth (Month Day Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, Social Security Number **Funeral** Days Min VIRGINIA 1 □ M 2 👽 F 70 216-36-5101 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, its Medical Examinat must be notified at 1 ☐ Yes 2 ☐ No Director COLUMBIA HOWARD MD. death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21045 Funeral 5621 TRICROSS DR 12. Was Decedent Ever in U.S. Armed Forces? 1 | Yes 2 D No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐Yes 2 ☑ No Specify. Specify: BLACK ģ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) DISABILITY DISABLED 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARGARET E. PHILLIPS ٥ WILLIE D. WHITE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health a 1526 HOLBROOK ST BALTIMORE, MARYLAND 21206 ROBERT HAMMON-BEY (GRANDSON) other. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20a. Method of Disposition to. Department of Important: If It any Injury or o once. 1 Burial 2 Cremation BALTIMORE, MARYLAND 6-17-2009 LOUDON PARK NATIONAL 4 □ Donation /5 □ Other (Specify) D. HIBNER Name and Address of Facility REDD FUNERAL SERVICE 21. Signatur MAHANO 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme of e Cause (Final disea or condition resulting in death) CHRONIC OBSTRUCTIVE PULMONARY **Physician** /Medical Due to (or as a consequence of): Examiner PLUGGING MUCOUS if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-trans Due to (or as a consequence of): attending pl for use as t F FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? art ||, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown

or Attending Physician: The law requires that the death certificate be executed Box 68760, P.0. Division of Vital Records, cate has been signification funeral director, this

After t

Hospital

the

within 2 o the F

Certification: 124 hours after death.

Funeral Director: Affetely filled in by the fur

Completed by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No
ed by Phys	9 ☐ Unknown Part II. Other significant condition
To Be Complet	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

27. Manner of Death

Medical

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 5 ☐ Pending investigation

26. Place of Death (Check only one

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

24a. Was an autopsy performe

1 ☐ Yes 2 🗷 No

29a. Certifier (Check only

1 Natural

2 Accident

4 Homicide

31. Date filed (Month, Day, Year)

3 ☐ Suicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

6 ☐ Could not be

29c. License number D 63242 29d. Date signed (Month, Day, Year) JUNE 14, 2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

COLUMBIA MD 21044

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CITTLE PATUXEM SHAH 10724 PANKWAY SUITE 200

State Registrar 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	Registrar 1. Decedent's Name (First, Middle, Last)		tificate of L	J Cutt 1	2. Date of Death June 14		Year	3. Time of Death
ian ical	Clara M. Wolff			L. Con of Dooth	June 14,	4c. Count		10:20 PM ^M
iner	4a. Facility Name (If not institution, give street and number) Stella Maris Hospice		Timonium	Location of Death		Balti		
	5. Social Security Number 216–14–4736 6. Sex 1 □ M 2 F 85	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 01/11/19	Year) 924	Co	hplace (State or Foreign untry) Yland
	Usual Residence of Decedent 10a. State 10b. County 10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits
tor	Maryland Washington Hage	rstown						1 □ Yes 2 Mo
Directo	10e. Street and Number 18203 Danby Ct.		10f. Zip Code 21740			og. Citizen of		
eral		S 13 \		lispanic Origin? (Sr		nited 14. Ba		erican Indian,
by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 □ 1 □ Yes 2 □ 1 □ Yes 3 □ 1 □ Yes 2 □ 1 □ Yes 3 □		f Yes, specify Cuba 1 □Yes 2	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Bli	ack, White ify: Wh	e, etc.
Completed by	15. Decedent's Education (Specify only highest grade completed)	(Give life. I		eation during most of work d)	king	16b. Kind of I		Industry
Com	8th	Homem	aker	40.44.0.3.14	ie (First, Middle, N	Domest		
Be	17. Father's Name (First, Middle, Last) Adam Kowaleski			Veronica		naideir Surna	ine)	
은	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street	and Number or Ru		City or Tow	n, State,	Zip Code)
	Robert Wolff III / Son			Court Be				
To Be Completed by Funeral Director	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Remoyal from State	Place of Dispo cemetery, crer	sition (Name of matory or other place	ce) 	İ	20c. Location	-	aryland 210
	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Encomortient Dul 21. Signature of Funeral Service Licenses	Laney V	ATTEA					al Homes PA
	21. Signature of Fulleral Service Endyses							land 21231
edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ursease or injury that initiated events resulting in death) Last DEMENTIA Due to (or as a consect of the condition of the consect of t	quence of):						
Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No 9 □ Unknown 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3	☐ Ectopic pregnand ☐ Other (specify)	су		1	Date of de Month	elivery Day Year
Š	Part II. Other significant conditions contributing to death but not re-	sulting in the u	inderlying cause giv	ven in Part I.	23e. Did to	12 M		o the cause of death? Probably 4 🗆 Unknow
Completed				Of Place of De	24a. Was a autope perfor 1 □ Yes	med? 2 X No	prior to death?	utopsy findings availab completion of cause of s 2 No
o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2▼No Hospital: 1 ☐ Inpatient 2 ☐	 ☐ ER/Outpatie	nt 3 DOA Ott				Other (Sp	ecify) HOSPICE
Certification: To	27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 2 Accident	28b. Time of Injury	Wo	iry at rk?]Yes 2□No	28d. Describe h	ow injury occ	urred	
ertifica	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At the building, etc. (Special Country)	home, farm, st	reet, factory, office		28f. Location (S City or Tow		mber or F	Rural Route Number,
	29a. Certifier 1 Certifying Physician: To the best of my kr (Check only one X Nurse Practitioner ner stated.	nowledge, dea nation and/or i	th occurred at the t nvestigation, in my	time, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) and date and place	manner ce, and du	as stated. ue to the cause(s)
ਰ			29c. Licen	se number		29d. Date sig	ned (Mor	nth, Day, Year)
Medical	29b. Signature and title of contifier		10.	1000-		, 1	11-	

10:20 р.ш.

JUNE 14, 2009

CLARA WOLFF

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 12:04 AM Mary June 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Johns Hopkins Bayview Medical Center Baltimore
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth May 2, 1933 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days 1□M 21 F Maryland May 219-28-9908 76 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a, State 10b County 10c. City, Town or Location show 1 ☐Yes 2 ☐ No permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any injury or other traumatic event, the Medical Examination in the Incition is once. Funeral Director Baltimore City Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21224 U.S.A. 22 South Potomac Street 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: δ White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frances Anuszewski Theodore Wojtas ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) East Lombard Street Baltimore, Md21224 Paula Guanti /daughter Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem Gar6-17-2009|Baltimore,Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licenses 1201 Dundalk Avenue Baltimore, Md.21222 When 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pulseless Electrical Activity 30 minutes Physician /Medical Due to (or as a consequence of): Examiner percarbic Respirator hours if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed Aspiration Preumonit and burial-trar to (or as a consequence of) P.O. Box 68760, physician Chronic Obstructive Polynonary Disease Exacerbation Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐ Yes 2 No ed by the detached if 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by sign be Obstructive. 3 Probably 4 Unknown 1 Yes 2 □ No page 2 should 24b. Were autopsy findings available prior to completion of cause of death? Fibrillation 24a. Was an autopsy performed: Physician: The Coagulopathy 1 ☐ Yes 2 X No 1 Yes 2 No : After this certification funeral director, p 25. Was ase referred to me cal examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

Ne Funeral Director: A pletely filled in by the fu death. 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of ceptifier

& A

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

RES-000

4940 Eastern Avenue Baltimore, MD 21224

June 14, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month June 8, 2009 8:34 A M Dennis Anthony Allio 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Charlotte Hall Charlotte Hall Veterans Home 8. Date of Birth (Month, Day, Year) 29mber 13,1929 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 1 **X**M 2 □ F Months Days Hours Onio 300-22-2745 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Maryland St. Mary's Charlotte Hall 10e. Street and Number 29775 Charlotte Hall Rd. 10g. Citizen of What Country? 10f. Zip Code 20622 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No 1948— If Yes, Give Year or Dates: 1951 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 X Married White 1 ☐ Yes X☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Army Navy Elementary/Secondary (0-12) College (1-4or 5+) Exchange Service Operations Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Aiello Angelina Ingolia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 29775 Charlotte Hall Road, Charlotte Hall, MD 20622 Emma L. Allio/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition June 9, 1 □ Buria 2X Cremation Brinsfield-Echols Crem. § ☐ Other (Specify) ation 2009 Charlotte Hall, MD 22. Name and Address of Facility of Funaral Service Licensee, Brinsfield-Echols F.H., P.A., 30195 Three Notch Rd., Charlotte Hall, DM 20622 M00817 Approximate Interval Between Onset and Death 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final CANCER METASTATIC disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a nonsequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 Other (specify) 2 □ No 23e. Did tobacco use contribute to the cause of death? FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an pertormed? Yes 2 2 No death? 1 ☐ Yes 2□ No 26 Place of Death (Check only one)

To the Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-trai Division or Vital Records, P.O. Box 68760, after death.

I Director: After this d in by the funeral di

Physician

/Medical

Examiner

Director

Funeral

δ

Be Completed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event; the Medical Examiner must be notified at another.

Physician

Baltimore, Maryland 21215-0036

/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner that initiated events resulting in death) Last Physician/Medical 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ CONGESTIVE Be Completed CORONARY 25. Was case referred to medical Certification: To 2 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier

	Zo. Flade of Boart (officer, officer)											
examiner?	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatient	3□ DOA	Other: 4 Nursing I	Home	5 Residence	6 ☐Other (Specify)					
7. Manner of Death 1. Natural 5 Pending investigat	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	- 1	Injury at Work? 1 ☐ Yes 2 ☐ No	28d.	Describe how inj	ury occurred					

28f. Location (Street and Number or Rural Route Number, City or Town, State) Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

D67788

.8.2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KODALI, Charlotte Hall, RAO

31. Date filed (Month, Day, Year)

32. Registrar's Signature

MD

State Registrar

10+16L

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death 2009 Dorothy Bell Marie 30 DM 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Salisburn Coastal Wicomico Lake 1-1050ice 0+ the 8. Date of Birth (Month, Day, May 4, If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) ^{Year)} 1928 Months Days Hours Min Delaware 1 M 2 X 222-18-8853 81 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b County 10c. City, Town or Location Yes 2 No Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 202 Meteor Ave., Apt. 204 21613 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: white 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elmer Joseph King unknown Anna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5315 Second Street, Cambridge, MD Richard E. King 21613 son Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State 6/1/09 Salisbury, MD Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ure of Funeral Service Licensee Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Static Due to (or as a consequence of) Mron c Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No 1 ☐ Yes 1 ☐Yes 2 NO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 NA 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

To the Hospital or Attending Physician; The law requires that the death certificate be executed physician and s the burial-trans P.O. Box 68760, attending p use as signed by the a Division of Vital Records, been s has e 2 s page certificate

Examine Physician/Medical à Completed director Be Certification: To

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show

Items 23a

'natural", or

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. is marked other than

Department of Health a Important: If item 27 is any Injury or other tra once.

Physician

Examiner

/Medical

Director

Funeral

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Completed

Be

MD

other traumatic event, the Medical Examinar must be notified at

this After thi funeral hours after death. uneral Director; Af n 24 houn. the Funeral Dire

within 24 2

State Registrar

Medical

29a. Certifier

28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Natural 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier 29c. License number

29d, Date signed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

relle 31. Date filed (Month JUN 02

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) June 2, Year 2009 **Physician** 11:24 AM Т. Barton Harold /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Camp Springs 7115 Westhaven Drive If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Hours Months 1 X M 2 □ F New York 114-03-1814 Aug. 18, 1917 91 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, it is Medical Examinational to a redifficed at 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 ☐ Yes 2 No Director Temple Hills Maryland Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20748 7115 Westhaven Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 M∑Yes 2 □ No if Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify þ 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Acquasition Legistic Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rose LaPenna Frances Basuino ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau
once. Alexandria, VA 22304 703 North Naylor Street, Mary Ellen Barton / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland June 8,2009 Resurrection Cem. 21. Signature Funeral Service Licensee 22. Name and Address of Facility
Lee Funeral Home, Inc. MUNKE 6633 Old Alexandria Ferry Rd. Clinton, MD 20735 M01391 23a. Parto. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Atherosclerotic Cardiovascular Disease vears Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to for as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Tyes 2 X No 3 Probably 4 Unknown Parkinsons Disease Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🔯 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Hospital: Other: 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27, Manner of Death 28c. Injury at Work? After 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No death, 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D19431 June 2, 2009 30. Name and address of person while pleted cause of death (Item 23a) (Type, Print) BB20 11701 Livingsont Rd. #103 Ft. Washington, MD Ryan, Frank M. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physicia /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Its Madical Exeminations to notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Stat Registrar

	1 - For State Registrar	Olato of Marylani	$C\epsilon$	ertificate of D	eath	F	Reg. No. 2	009	19	639
	1. Decedent's Name (First, Middle, La	ist)				2. Date of Dea	ith		3. Time of	Death
n	Paul Elmer Caspa	r				June 8	. 2009	Year)	3:2	5 A ^M
ıl 	4a. Facility Name (If not institution, give			4b. City, Town, or L	ocation of Death	-,0 4110 0		nty of Death		
r				Solomo				Calver	+	
-	Solomons Nursing 5. Social Security Number 6.8		ast birthday		If Under 24 Hrs.	8. Date of Birt (Month, Day		9. Birth	place (State of	or Foreign
		1⊠M 2□F	85 Yrs.	Months Days	Hours Min.	July 7,	1923		intry) ict of C	'olumbi
	Usual Residence of Decedent		ره			July /,	1923	DISCI.	ict of C	OTUINDI
	10a. State 10b. County	10c. Cit	, Town or L	Location					10d. Inside C	ity Limits
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e S	Maryland St. Mar	у Б	·	10f. Zip Code	.ywoou		10g. Citizen	of What Cou	intry?	
Funeral Directo	24206 Half Pone	Doint Dood		20636			_	USA		
era		12. Was Decedent Ever in U.	C 12		nanic Origin? (Spe	ecify Ves or No-	14 F	Race - Ameri	ican Indian	
Ş	11. Marital Status	Armed Forces?	3.	B. Was Decedent of His If Yes, specify Cuban	, Mexican, Puerto	Rican, etc.)	E	Black, White,		
×	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ⊠Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Spe	ecify: Wh	ite	
Completed by			16a Dec	cedent's Usual Occupat	tion		16b Kind o	f Business/Ir	ndustry	
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ם	Elementary/Secondary (0-12)	College (1-4or 5+)	inc.	Plaster			Conc	struct	ion	
	12 17. Father's Name (First, Middle, Last	<i>t</i>)			18, Mother's Name	/First Middle			1011	
Be										
2	Christian Caspa					ophia C				
	19a. Informant's Name/Relationship			iling Address (Street a						_
	John Anthony Casp			6 Half Pon				od , MI on - City or T	20636)
	20a. Method of Disposition 1 ☐ Burial 2 ☆ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	emetery, cr	position (Name of rematory or other place an Crematory	June 8	, 2009	Alexand	•		
	21. Signature of Funeral Service Lice	nsee		22. Name and Address Mattingley P.O. Box 2	-Gardiner I	Funeral H	ome, P.	Α.		
- 1	23a. Part 1. Enter the disease, or com-	lications that caused the deat	n. Do not e						Approxima	te
	shock, or heart failure. List only Immediate Cause (Final	one cause on each line.							Interval Be Onset and	Death
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an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	death 3	3 ☐ Ectopic pregnancy			23d.	Date of deli Month	very Day	Year
Physician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of o 9 ☐ Unknown	leath 5	5 ☐ Other (specify)						
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ble						24a. Was		4b. Were aut	topsy findings	available cause of
E O						perfo	rmed? 2 2 No	death? 1 ∐ Yes	2 No	
O	25. Was case referred to medical				26. Place of Deat	L	one)			
0	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpat	tient 3 DOA Othe	r: 4 Nursing Ho	me 5 ☐ Resi	dence 6 🗆	Other (Spec	cify)	
Ë	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time Injury	e of 28c. Injury y Work'	at	28d. Describe	how injury oc	curred		
atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		_ ′ ′		es 2 □No					
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Medical Certification: To	29a. Certifier 1 (Check only one) 1 ✓ ertifying P Medical Exa	Physician: To the best of my kno aminer: On the basis of examina and manner stated.	owledge, de ation and/or	eath occurred at the tim r investigation, in my op	ne, date and place, pinion, death occur	, and due to the red at the time,	cause(s) an date and pla	d manner as ace, and due	s stated. to the cause	(s)
Mec	29b. Signature and title of certifier	C		29c. License	number		29d. Date si	igned (Montl	h, Day, Year)	
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			- 00-1 /=					')	*	
	30. Name and address of person who				T are to the	Dorel 100	20652			
	Charles M. Benner, M 31. Date filed (Month, Day, Year)	D. 20945 Great M		oad Ste. 203	Lexington	rark, ML	20033			
e ir	JUN 0 8			power						

State Registrar

31. Date filed (Month, Day, Year)

RAO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KODALI, Charlotte Hall, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** June 9, 2009 1:11 p.mM Joseph Mason Curtis /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 16879 Three Notch Road St. Mary's Dameron If Under 1 Year Months Days Social Security Number 7. Age (In yrs. last birthday If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours 1 XM 2 ☐ F Director 214-32-7761 Yrs 07/09/1933 75 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; if then 27 is marked other than "natural", or items any injury or other traumath. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland St. Mary's Dameron 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16879 Three Notch Road 20628 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 XNo à 3 Widowed 4 Divorced **Black** Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner Tire 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Henry Curtis Helen Rebecca Mason 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Curtis/Wife 16879 Three Notch Road, Dameron, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Cem. 06/13/2009 Leonardtown, Maryland 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle S. Simons M01206 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Within 24 hours after death.

Othe Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 □Yes 2 □No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform とつ ormed/? 2 🗹 No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Nursing Residence} \) 6 \(\text{Other} \) Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide hysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Important the time is a state of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 1 ertifying Medical 2 ☐ Medical Ex 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person

31. Date filed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

6-10-09

1 - For Stat Reg 1. Deced

> St 5. Social

To Be Completed by Funeral Director

Physician

Examiner

Funeral

Director

/Medical

Physician /Medical Examiner

For State Registrar			C	ertifica	te of	Death		Reg	j. No. 4	2000	1 100	J. 1
Decedent's Name (First, Middle, La	ist)			-			\Box	Date of Death Month	Day	Year	3. Time of Di	eath
Susan Curtin	n Cook							June	10,	2009	1:19 [РМ
. Facility Name (If not institution, giv		_	_			or Location of De	eath			County of Deat		
St. Mary's Hosp:		e (In yrs. la	st hirth d		eonar	rdtown If Under 24 F	Hrs. T	8. Date of Birth		St. Mai	thplace (State or F	Forein
*	Sex 7. Age 1 □ M 2 🛣 F	62	ist <i>birthda</i> Yrs.	Months			/lin.	8. Date of Birth (Month, Day, 11/20/19		CC	Virgi:	
sual Residence of Decedent								, -0, 13				
Da. State 10b. County		10c. City,	Town or	Location							10d. Inside City	
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1. Marital Status	12. Was Decedent 8 Armed Forces? 1 □Yes 2 ▼ N		o. 1	o. vvas Dec If Yes, sp	eaent of I ecify Cub	Hispanic Origini an, Mexican, Pu	r (Sp∈ uerto i	Rican, etc.)	1	 Race - Ame Black, White 		
1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ∐Yes 2 X N If Yes, Give Year or Dates:	_		1 □Yes	2 X No	Specify:			5	Specify:	White	
15. Decedent's E	ducation		16a. De	ecedent's Us	iual Occup	pation	IA IA	16	3b. Kind	d of Business		
(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or 5	+)				during most of ed)					1	
12			Adm	inist	rativ	re Assis				ospita.	<u>T</u>	
7. Father's Name (First, Middle, Last								e (First, Middle, Ma	_	ourname)		
	ctin					Rub		Rus		T-	7:- 0 / :	
9a. Informant's Name/Relationship					•			al Route Number, (-			
Heather L. Bowle	es/Daughter							anicsvil.		MD 206 ation - City or		
Da. Method of Disposition 1⊠ Burial 2 □ Cremation 3 □				sposition (Note that the control of		ice)				nardto		
4 □ Donation 5 □ Other (Special		lona	.r.res			1						m c
1. Signature of Funeral Service Lice	PUSTR							nsfield- Rd., Cha				
3a. Part 1. Enter the disease, or com	iplications that caused	the death	. Do not							11d.	Approximate	
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Sequentially list conditions, fany, leading to immediate	b. Due to (or as											
any, leading to immediate ause. Enter Underlying Cause (Disease or injury hat initiated events	c. Acut	е Муо	card	ial I	nfaro	ction	_					
esulting in death) Last	Due to (or as											
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F FEMALE:												
23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 🗌 Fetal	death	3 ☐ Ectopic					2	3d. Date of de	,	ear
1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown			5 Other (- ~, 10	
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art II. Other significant conditions Renal Failur		at HUL FESU	y iri th	unueriyinç	, vausie gi	.vomm FdI(I.				Se contribute t	/	
								24a. Was an autopsy		prior to	autopsy findings av completion of car	vailable use of
									No	death? 1 ☐ Ye	s 2 No	
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1 Yes 2 No	1 Yinpatie		· · · · · ·	atient 3 🗌	DOA			ome 5 Resider			ecify)	
7. Manuer of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da	y, Year)	28b. Tim Inju			uryat ork? ⊒Yes 2 ⊒No		28d. Describe how	a injury	Destrict		
2 Accident investigation 3 Suicide 6 Could not be		Jrv - Δ+ L -	me form					28f. Location (Stre	201 0-	Number or F	Rural Route Mumb	per
4 Homicide determined		c. (Specify	o, iarm,	, sucet, IACI	ory, UHICE			City or Town,			, route rvurill	
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		of my kno	wledge d	leath occurr	ed at the	time, date and	place	and due to the or	use(e)	and manner	as stated.	
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06/12/2009

State Registrar

Medical Certification: To Be Completed by Physician/Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



MD.

D60888

DHMH 17 Rev 1/2001

		-	For State Registrar	State of Ma	ii yianu / i		tificate of L	ieaith and iv Death	iciliai i iy	Reg. N	_ /	9	19	643
			Decedent's Name (First, Middle, La	ast)					2. Date of Do	eath		ear	3. Time of	Death
	Physicia /Medic		IGNATIUS	PUTMAN	DUTROW					12,	2009		2:18	ΑM
	Examin		4a. Facility Name (If not institution, gi					Location of Death		4	c. County of I Frede		l _e	
**			Frederick Memoria 5. Social Security Number 6.	L.	e (In yrs. last bi	rthday)	Freder	If Under 24 Hrs.	8. Date of Bi	rth			lace (State o	or Foreian
Н	Funeral Director		219-20-0847		32	Yrs.	Months Days	Hours Min.	8. Date of Bi (Month, D 6-9-19	927	r)	Coun	MD	
	ъ		Usual Residence of Decedent					· · · · · · · · · · · · · · · · · · ·				11	0d. Inside C	ity Limito
	arylar show	7	10a. State 10b. County	1.	10c. City, Tow							'		2 □ No
	28a-f	Director	MD Freder 10e. Street and Number	rick	Free	deri	10f. Zip Code		_	10a. C	Citizen of Wha	ıt Coun	itry?	
	with 3a or	Ö	120 East 3rd Stre	aet			21701				USA			
	death	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13. V		ispanic Origin? (Sp un, Mexican, Puerto	ecify Yes or N		14. Race - Black,			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinar must be rediffed at once.	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 X Yes 2 □ I If Yes, Give Year or Dates:	wwII,Ko			Specify:	riidan, etc.)			Whi		
2-0	72 hou natura	Completed	15. Decedent's E (Specify only highest gr		16a	a. Deced	ent's Usual Occup	ation during most of work	ina	16b.	Kind of Busin	ess/Ind	dustry	
2	ithin 7 ne. han "r	mple	Elementary/Secondary (0-12)	College (3-4or 5	i+)	life. D	oo NOT use retired ter Pluml	1)	9	p1	umbing	r		
2	iled w Hygie Ither tl	CO	17. Father's Name (First, Middle, Las	t)		rias	ter rrain	18. Mother's Nam	e (First, Middl					
au	d be f ental ked o ic eve	To Be	Robert Thomas Du					Mary Pu						
ary	shoul and M s mar umat	۲	19a. Informant's Name/Relationship		19	b. Mailin	g Address (Street	and Number or Rui	ral Route Num	ber, City	y or Town, St	ate, Zip	Code)	
Σ	and 2 salth a n 27 is		Anne Dutrow	Wife				Street Fr						
Baltimore,	ges 1 t of He If iten or oth		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 [☐ Removal from State	20b. Place of cemeter	of Dispos ery, crem	sition (Name of natory or other plac		Date		Location - Ci			
Ħ Ħ	t. Pag rtmen rtant: njury		4 □ Donation 5 □ Other (Spec	ify)	Union				-2009					
Bai	permi Depar Impor any ir once,		21. Signature of Funeyal Service Lice	non	M01176			^{ss of Facility} Kee hurch Str						
													Approxima Interval Be Onset and	tween
Eq.	Physician												480	
1	/Medical Examiner		resulting in deathy	Due to (or as	a consequence	of):			X		£.:			
3	TAIL .	jer	Sequentially list conditions,	b. Oue to (cras	a consequence	(fi)								
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C										
Ő,	oe exe sian al urial-t		resulting in death) Last	Due to (or as	a consequence	of):								
68760,	tificate be executed ng physician and as the burial-transit	edical		d										
			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. Date	of deliv	ery	
P.O. Box	Attending Physician: The law requires that the death certificate be executed refeath. setor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown			Ectopic pregnanc Other (specify)	<u> </u>			Monti	h	Day	Year
σ.	that the	/ Ph	Part II. Other significant conditions	contributing to death b	ut not resulting	in the ur	nderlying cause giv	en in Part I.	23e. Did	tobacc	o use contrib	ute to t	he cause of	death?
Division of Vital Records,	quires in sign	Completed by	Atrialtib	r1/19+10	n, Rei	201	fail	ure	1 [Yes	2 □ No 3	☐ Pro	bably 4	Unknown
000	aw rec	plete			,				24a. Wa	as an topsy	24b. We	ere auto	opsy findings ompletion of	s available
m m	The la	mo							per 1 🗆 Yes	rformed	? de	ath?	2 □No	04400 01
/ita	cian: ertific	Be (25. Was case referred to medical examiner?				1011	26. Place of Dea	th (Check only	one)				
of \	Physi this o		1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpati	ent 2 ER/C	Outpatier . Time of		4 🗆 Nuising n			e 6 □Other	• •	ify)	
O	ding h. After funer	tion	1 Natural 5 ☐ Pending	(Month, Da	y, Year)	Injury	Wor	k? Yes 2□No	20d. Describ	C HOW II	ijury occurred			
/isi	Atten r deat sctor: by the	fica	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of In		farm, str	eet, factory, office		28f. Location	(Street	and Number	or Run	al Route Nu	mber,
á	al or s after	Certification: To	4 ☐ Homicide determine	building, et	c. (Specify)				City or T	OWII, SI	ate)			
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical (29a. Certifier 1 Certifying F (Check only one) 2 Medical Ex-	Physician: To the best aminer: On the basis of and manner st	of examination a	ge, deat and/or in	h occurred at the ti vestigation, in my o	ime, date and place opinion, death occu	e, and due to the arred at the time	ne caus le, date	e(s) and man and place, an	ner as id due t	stated. to the cause	e(s)
	To th withir To th comp	Me	29b. Signature and title of certifier		,	å a	29c. Licens				Date signed			_
			1/6	Fauzi 1	11211	1 M	D MDD 6	52180		J	Tune	. 1	2,20	700
			30. Name and address of person wh	•					, .	0.4				
	St.	te.	Dr. Fauzi Razvi 31. Date filed (Month, Day, Year)	32 Regist	rar's Signature			rıck, Mar	y⊥and_	21/0)			
			Registrar JUN 18 2009 August 18 4 August 18 August											

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DHMH 17 Rev 1/2001

			Ctate of Maryland / Department of Lealth and Martel Hygians	
			State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1 1 9	061.1.
				me of Death
	Physici	an	Month Day Year	05 M
4.78	/Medid Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	00
1	Lxaiiiii	iei	The Memorial Hospital Easton Talbot	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (S. Country)	tate or Foreign
	Director		222-12-0303 10 20 8 4 Yrs. Feb. 25, 1925 New 7	Tersey
	and ww.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Insi	de City Limits
Q	Maryland I-f show fied at	ĕ	MD Talbot Trappe	Yes 2 Mo
H	r 28a	irec	MD Talbot Trappe. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
7	h with	Funeral Director	29160 Krismore Court 21673 25A	
4	ems army	iner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Hispanic Origin?) 14. Race - American India If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	an,
36	or it	by Fu	1 Never Married 2 Married 1 Yes 2 No	
21215-0036	72 hours after death with the natural", or items 23a or 28a	P P	3 Mad Wildowed 4 □ Divorced Year or Dates:	
15	in 72 "nat	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry	
212	within jiene.	E O	Elementary/Secondary (0-12) College (1-40r5+) Elementary Teacher County Board C	F Ed.
	should be filed vand Mental Hygies marked other tumatic event, In	BeC	17. Father's Name (First, Middle, Last) Elementary teacher County Board of the state of the sta	
/lar	uld be Vents Irked Itic ev	To E	Earl Crampton Mabel Estenday	
Maryland	2 sho and l is ma		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Pate, Zip Code)	
	t and 2 Health em 27 ither tra	l s	William Fassett 2835-15 th Ave. Regina, SK 54T15	6
Baltimore,			20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State	ite .
ţim	permit. Pages Department of Important: If i any injury or once.	1.7	4 Donation 5 Other (Specify) Mid Share Cremation 6/3/09 cambridge	MD.
Bal	permit. Departr Importa any inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility HENRY FUNERAL HOME, P.A. 510 washington Str Cambridge, MD 216	1 '2
			L 23a. Parkl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.	ximale
	Dhi.i		shock, or heart failure. List only one cause on each line. Onset	al Between and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. AS pivation presulting in death) Due to (or as a consequence of):	p
T	Examiner	Ш		
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Indepting. Due to jor as a consequence of:	
	ocuter nd transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	
760,	oe exe sian a urial-		resulting in death) Last	
6876	eath certificate be executed attending physician and for use as the burial-transit	dical	d	
9 X	certifi ding I	Physician/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	
Вох	atten for us	cian	in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day	Year
0	at the de by the tached	ysi	1 Yes 2 No 9 Unknown 9 Unknown	
σ.	res that signed b be deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause	e of death?
ğ	quire en sig uld bi	pa pa	Concestre heart failure, Clastone 1 Yes 200 No 3 Probably	4 🗌 Unknown
Color Colo			rheintril arthits 24a. Was an autopsy find autopsy prior to completion	tings available
ĕ	: The law cate has page 2 s	mo;	Por nutrition autopsy prior to completion death? Town nutrition 1 Yes 2 No 1 Yes 2 Yes 2 No 1 Yes 2	
/ita	sician: The certificate rector, pag	Be C	25. Was case referred to medical examiner? 26. Place of Death (Check only one)	
₹ \	hysic his ce I dire	은	1 ☐ Yes → No Hospital: 1 ☐ Hospital: 1 ☐ Hospital: 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
ū	ding Phys h. After this (funeral dir	iu o	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Work? 28c. Injury at Work? 28d. Describe how injury occurred Work?	
Sio	ttend death ttor: / the f	icati	2 Accident investigation 3 Suicide 6 Could not be 280 Place of Injury. At home farm street feature of figure 1 and Number or Pure! Pout	Mumber
Division	l or Attendi after death. Director: /	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route City or Town, State)	rivarriber,
_	spital		29a. Certifier CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the call and manner stated.	use(s)
	To the within To the Comp	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Ye	ear)
	0.		11-1 64045 may 51, 20	0/
	N		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ay L 13. Monte 219 S. Washington St. EASTON, M. 216	21
			31. Date filed (Month, Day, Year) 32. Registrar's Signature	201
	Sta Registr		JUN 0 3 2005	
-	3,		OUR OU COURT FRANCE IS.	

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	_1	I - For State Registrar Cel	rtificate of Death		.No. 2009 1961
Physicia /Medic		1. Decedent's Name (First, Middle, Last) Phyllis Jean Pelletier Fuhr		Month	Day Year 4 2009 06:15 AM ^M
Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	١	4c. County of Death Cecil
Funeral Director		177 Willard Drive 5. Social Security Number 216-48-2243 6. Sex 1 □ M 2X F 63 7. Age (In yrs. last birthday) 6. Sex 1 □ M 2X F 63	North East If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	9. Birthplace (State or Foreign Country)
then "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Low Marvland Cecil North E			10d. Inside City Limits 1 □ Yes 2XXXI
la or 28a- t be notifi	Dire	Maryland Cecil North E 10e. Street and Number 177 Willard Drive	10f. Zip Code 21901		Dnited States
ntal Hygiene. od other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral		Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 【XNo Specify:	pecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
e. an "natura Medical E	Completed	(Specify only highest grade completed) (Give life. Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired)	rking	5b. Kind of Business/Industry
	Con	12 Ho	memaker	me (First, Middle, Ma	Own Home
nd Mental Hygi marked other imatic event, t	Be	17. Father's Name (First, Middle, Last) Lewis Owens		rie Ledin	
f Health and Mer Item 27 is marke other traumatic	2	19a. Informant's Name/Relationship (Type. Print) 19b. Mail	ing Address (Street and Number or R Willard Drive, No	ural Route Number, (City or Town, State, Zip Code)
0		11 Burial 2 MCremation 3	osition (Name of ematory or other place) Jun Jun Crematory 200	ie 5,	oc. Location - City or Town, State
Department Important: I any injury o		21. Signature of Funeral Service Licensee	22. Name and Address of Facility (27 South Main Str		eral Home h East, Maryland219
g physician and as the burial-transit	edical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	ancer		
	Physician/Medi		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
signed by d be detac	β	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death? s 2 No 3 Probably 4 Unkno
certificate has been signed by the attendir rector, page 2 should be detached for use	Completed				prior to completion of cause death? 1 □ Yes 2 No
r death. ector: After this by the funeral di	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Accident 1 Inpatient 2 ER/Outpatient 2	of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how	nce 6 Other (Specify) w injury occurred eet and Number or Rural Route Number,
24 hours afte Funeral Dir etely filled in	Medical Cer	29a. Certifier (Check only one) 29a Certifying Physician: To the best of my knowledge, de edical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and pla investigation, in my opinion, death oc	ce, and due to the ca curred at the time, da	nuse(s) and manner as stated. ate and place, and due to the cause(s)
within 2 To the complete	Mec	29b. Signature and the of certifier	Doos 6	449 25	od. Date signed (Mdnth, Day, Year)

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

			Registrar	Cei	rtificate of	Death		Reg. No	009	13040
	Physici	an	1. Decedent's Name (First, Middle, Last)	1			2. Date of De Month	Day	Year	3. Time of Death
	/Medi		NOLAN K. GOOD	1			June	- 2	2009	1235 M
Ì	Examir	ner	4a. Facility Name (If not institution, give street and number) TENINSUUA REGIONAL MESULA C	Centr	4b. City, Town, o	AUSBUM			Inty of Death	->
	Funeral		5. Social Security Number 6. Sex 7. Age (In y	rrs. last birthday)	If Under 1 Year Months Days	If Under 24 Ars. Hours Min.	8. Date of Bir (Month, Da	ay, Year)	9. Birthp	place (State or Foreigntry)
	Director	i i	231-32-7891	76 Yrs.			June 2	, 1933	Virg	
	w		Usual Residence of Decedent 10a, State 10b, County 10c.	City, Town or Lo	ocation				1	10d. Inside City Limits
	f sho	ō								1 □Yes 2★□No
	28a-	Director	MD Somerset We	estover	10f. Zip Code			10a. Citizen	of What Cour	ntry?
	with sa or	Ö								,
	ns 23	Funeral	7278 Mennonite Church Road 11. Marital Status 12. Was Decedent Ever in	U.S. 13. 1	21871 Was Decedent of I	Hispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No		JSA Race - Americ	can Indian,
(C)	fter o	五	Armed Forces? 1 ☐ Never Married 2 Married 1 ☐ Yes 2 Married				Rican, etc.)		Black, White,	etc.
ğ	al", o	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1 □Yes 2 No	Specify:		Spe	ecify: wh	nite
2-0	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show Is Modeol Expriment rest be redflied at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decer	dent's Usual Occu	pation during most of working	na -	16b. Kind o	f Business/In	dustry
21215-0036	within lene. than"	효	Elementary/Secondary (0-12) College (1-4or 5+)	life.	DO NOT use retire	d)	.9			alastuosi
	ed w lygie her tl				sales	18. Mother's Name	/Final Ministra			electroni
ınd	ould be filed v Mental Hygie rarked other t	Be	17. Father's Name (First, Middle, Last)			_		, maiden Sun	name)	
<u>}</u>	should and Mer s marke umatic	မ	Kenneth G. Good	1			Brunk		0: : 7:	
Maryland	12 sho th and 7 is ma trauma		19a. Informant's Name/Relationship (Type. Print)		,	and Number or Rura				
ď	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Macketl Examinar must be redflied at	. 1	Mildred Good (wife) 20a. Method of Disposition 20i			e Church I	ate W€		on - City or To	
Baltimore,	of ± t b		Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, crer	osition (Name of matory or other pla	ı		2001 200411	o., o., o. ,	o mi, o tato
≣	Departmen Departmen Important: any injury once.		4 □ Donation 5 □ Other (Specify)	olly Grove monite C	emetery	6/6/2		Westo	ver, M	D
Ba	Depar Impo any ir		21. Signature of Funaral Service Licensee	ĦĆ	lloway F	uneral Hor treet, Po	ne, Pro	fession	al Assoc	jațion
			23a Part 1 Enter the disease or complications that caused the di						MD 216	
			23a. Part 1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line. Immediate Cause (Final			rig, sucir as cardiac c	i respiratory o	11031,	1.	Approximate Interval Between Onset and Death
- 1	Physician /Medical		disease or condition a.		ilure				/	week.
-	Examiner		Due to (or as a cons		In D	stress				ZWK
		ē	Sequentially list conditions, if any, leading to immediate		rocy vi	317855			-	
	uted d insit	듩	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ONIA	_					3WK
Ć.	exec in and ial-tra	Examiner	resulting in death) Last C. Due to (or as a cons	equence of):			-			-
68760,	certificate be executed ording physician and ise as the burial-transit	ca	d							
89	tifica ng ph as th	n/Medical								
		N/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ F		☐ Ectopic pregnan	~·		23d.	Date of deliv	•
n n	The law requires that the death ate has been signed by the atter page 2 should be detached for u	Physicia	1 Yes 2 No 4 Pregnant at time		Other (specify)				Month	Day Year
л Э	at the de by the	h	9 Li Unknown							
ú	res that signed I be deta		Part II. Other significant conditions contributing to death but not i	resulting in the u	ınderlying cause gi	ven in Part I.		7		the cause of death?
סב	w require been significations in the second to the second	Pe	CUA				10	Yes 2	lo 3⊟ Pro	bably 4 Unknow
ပ္	law r as be 2 sh	Completed by					24a. Was		4b. Were auto	opsy findings availabl empletion of cause of
r	: The l	ě					perfo 1 □ Yes	ormed?	death? 1 ∐Yes	
<u>I</u>	sician: The certificate l rector, page	Be (25. Was case referred to medical examiner?			26. Place of Death				
<u> </u>	G: 55. 💢		1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatier	nt 3 □ DOA Oti	ner: 4 🗆 Nursing Hor	me 5 ☐ Res	idence 6	Other (Speci	ify)
_ _	ffe ffe	ü	27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year	28b. Time of Injury	Wo	rḱ?	28d. Describe	how injury oc	curred	
<u>S</u>	Attending r death. sctor: After by the funer	cati	2 Accident investigation			Yes 2□No				
Division of Vital Records,	or At fter d jirect in by	Certification: To	4 Homicide determined 28e. Place of Injury - A building, etc. (Spe	t home, farm, str ec <i>ify)</i>	reet, factory, office	1	28f. Location (City or To	(Street and N wn, State)	umber or Rui	ral Route Number,
	urs a		CO. Continue Division To the head of					(-)	d	state d
	Hosp 24 ho Fune stely f	ical	29a. Certifier 1 ★ Certifying Physician: To the best of my (Check only one) 2 ★ Medical Examiner: On the basis of exam							
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	one) and manner stated. 29b. Signature and title of certifier		29c. Licen	se number		29d. Date si	gned (Month)	, Day, Year)
	F ≥ F 8		1/20P Min an					6/3	,	
•			20 Nome and address of accounts and	Itam ODal (T	Deint\	0 1 2		-13	, -,	
4	8A5		30 Name and address of person who completed cause of death (I	Item 23a) (Type,	POLA	872 mode N	10 3	2185	/	
í	Sta	ete.	31. Date filed (Month, Day, Year) 32. Registrar's Signature 33. 33. 33. 33. 33. 33. 33. 34. 35. 35. 35. 35. 35. 35. 35. 35. 35. 35		1,000					
	Registr		JUN 0 4 2009	. 1 1	backet					

DHMH 17 Rev 1/2001

Division of Vital Becords P.O. Box 68760

	1 - State Registrar	Cer	tificate of Death	Reg	No.2009 1964
sician edical	1. Decedent's Name (First, Middle, Last) Sara Garrett			2. Date of Death Month	Day Year 3. Time of Death 26 2009 11:57 A M
miner	4a. Facility Name (If not institution, give street and number University of Mayland Medi	in Center	4b. City, Town, or Location of Death		4c. County of Death
eral tor	216-38-9994 1 M 2XX	Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Young)	9. Birthplace (State or Foreig Country) MD
o.	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation		10d. Inside City Limit XX Yes 2 □ N
Director	MD TALBOT 10e. Street and Number	BASIUN	10f. Zip Code	10g	. Citizen of What Country?
To Be Completed by Funeral Director	7407 BURGESS CT 11. Marital Status 1 □ Never Married 2 □ Married 3XXWidowed 4 □ Divorced 1 □ Year or Date:	X No 1	21601 Vas Decedent of Hispanic Origin? (Silves, specity Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-40)	16a. Deced (Give life, L	ient's Usual Occupation kind of work done during most of wor 30 NOT use retired)		b. Kind of Business/Industry OWN HOME
To Be Co	17. Father's Name (First, Middle, Last) HENRY ALFRED SPIES	HOTH		ne (First, Middle, Ma	
	19a. Informant's Name/Relationship (Type. Print) SANDRA DULIN DAUGHTER	_	g Address (Street and Number or Ru BURGESS CT EAST	on, MD 21	
	20a. Method of Disposition 1 X Kurial 2 Cremation 3 Removal from Sta	20b. Place of Dispos	sition (Name of natory or other place)		c. Location - City or Town, State
once.	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	EASTERN S	. Name and Address of Facility	30–2009	HURLOCK, MD AM FUNERAL HOME, P., MD 21601
an cal ner		sed the death. Do not ente			
ical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	as a consequence of):			
Physician/Medical		h 2 ☐ Fetal death 3 ☐ It at time of death 5 ☐	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
à	Part II. Other significant conditions contributing to death	n but not resulting in the ur	nderlying cause given in Part I.	23e. Did toba 1 □ Yes	cco use contribute to the cause of death? 2 ☑ No 3 ☐ Probably 4 ☐ Unknow
Completed				24a. Was an autopsy performe 1 □ Yes 2	24b. Were autopsy findings availab prior to completion of cause o death? No 1 □ Yes 2 No
To Be Comp	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Input	atient 2 🗆 ER/Outpatier	Other:	ath <i>(Check only one)</i> Home 5 ☐ Residen	ce 6 ☐ Other (Specify)
	2 Accident investigation	njury 28b. Time of Injury	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how	injury occurred
Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of building.	Injury - At home, farm, streetc. (Specify)	eet, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
Medical (29a. Certifier (Check only one) Certifying Physician: To the bear and manner	s of examination and/or in	n occurred at the time, date and plac vestigation, in my opinion, death occ	e, and due to the cau urred at the time, dat	use(s) and manner as stated. e and place, and due to the cause(s)
ž	29b. Signature and title of certifier	0 40	29c. License number P14550		1. Date signed (Month, Day, Year)
		-	7 (73 > 0		1 - 1 - 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** М Gettv Nelson Josephine 2009 June 12. 0632 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Allegany
9. Birthplace (State or Foreign
Country)
MA Cumberland Memorial Hospital r 24 Hrs. T 8. Date of Birth (Month, Day, Ye May 13, 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 □ M 2 □_XF Months 017-14-6738 90 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a State 10h Count 28a-f show ral", or items 23a or 28a-f shov Examiner is ust be notified at Allegany MD Cumberland 1 ☐Yes 2 ☐ No **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1 Baltimore Street 21502 USA Pages 1 and 2 should be filed within 72 hours after death \u00e4nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 □Yes 2 No If Yes, Give Year or Dates: Specify: ģ white 3 Nidowed 4 Divorced "natural", Be Completed ih and Mental Hygiene.
7 Is marked other than "natur traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Health Care Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jean (Smith) Nelson Joseph A. Nelson ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
115 Luteman Road Cumberland MD 19a. Informant's Name/Relationship (Type. Print)

Jeffrey Getty MD 21502 Department of Health ar Important: If Item 27 Is any Injury or other trau once. son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Scarpelli Funeral Home, P.A. 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 6/13/2009 MD Cresaptown 21. Signature of Funeral Service Licens 22. Name and Address of Facility at Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a Part 1. Enter the diseal e, or comilic, tion it at gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one each line.

Immediate Cau e/(Final disease or con altion resulting in de (tr))

a.

Due to (or as a consequence of): Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially ist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Quality for as a nonsequence of Examiner attending physician and for use as the burial-tra Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 m onths?
1 □ Yes 2 □ No 3 Ectopic pregnancy Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 3 Probably 4 ☐ Unknown 1 □ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 → res 2 → No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 909 04/8 Fe 11 AT BESIDENE 1 □Yes 2 No 6 death. 2 Accident lac of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State)

\$\mathbb{BAIT(\text{North} & S) (UMB,}\$ 3 Suicide 28e determined 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, thin 24 hours after death.

the Funeral Director: A mpletely filled in by the fu within 2

Baltimore, Maryland 21215-0036

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 00066606 June 2009

OLAIDE ATAMI, M.D address of person who completed cause of death (Item 23a) (Type, Print)

HOSPIMA, CUMBERUMO, MD AJAHI, M.D 31. Date filed (Month, Day, Year)

State Registrar

Medical

32. Registraris Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Joseph State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Phyllis Josephine Highsmith June 2, 7:50_A 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Germantown 12935 Pickering Drive Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🔽 F 579-22-0049 Washington, D.C 1924 Director Feb 12, 85 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Evantime must be realthed at 1 ☐ Yes 2 XNo Director Rockville MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 20851 1920 Lewis Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ∐Yes 2 XNo Specify: Specify: White ð 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Perroine Frank Bredice ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12935 Pickering Dr. Germantown, MD 20874 Linda Lee/daughter Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages Department of Important: If it any injury or or 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State W. Arundel Crematory 06/05/09 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Funeral Service Lic Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Leve 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Heavt Physician enolete 2 weeks /Medical Due to (or as | consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last MYONIC Due to (or as a consequence of): Examine death certificate be executed burial-tran Due to (or as a consequence of): 68760 Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4 ☐ Pregnant Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 🔣 No detached o 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records. cate has been sign page 2 should be 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown ementic Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 24 No certificate 1 ☐ Yes 2 ☐ No Vital 1 ☐ Yes Physician: 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2₺ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To ot this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Hospital or Attending Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) p 4 ☐ Homicide filled in ** Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number June, 3, 2009

1080

State Registrar

Date filed (Month, Day Year) 5 2009

S. Abulfaras,

M.D. 604 S. Frederi 5 2009 32. Régistrar's Signature

30. Name and address of person who come ed cause of death (flem 23a) (Type, Print)

Frederick Rd. Gaithersburg, MD 20877
strar's Signature

A. Sauks

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) June 3, 2009 **Physician** 7:00 A Hoffman John Charles /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's Charlotte Hall Veterans Home Charlotte Hall Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Feb. 28, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 XXM 2□ 579-20-4275 Yrs Washington, DC Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner mast be notified at once. 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location 1 ☐ Yes 2 XXNo Director Maryland Prince George's Temple Hills 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2706 Kenton Place 20748 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 104 11. Marital Status Black, White, etc. 1943-1 KLWYes 2 □ No 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: White 1 ☐ Yes 2XXX No Specify: þ 1944 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School Principal D.C. School System 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Hoffman Elizabeth Frederick Whalen ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary P. Hoffman / Wife 2706 Kenton Place Temple Hills, Maryland 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State \$t. Mary of Sorrow Cem. 06/06/2009 Fairfax, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 21. Signature of Funeral Service License Iles 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Alzhumen End - Stage /Medical Due to (or as a consequence of) Examiner rostati Canuk Sequentially list conditions, if any, leading to infine flate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical D'ardiomy apath IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 □Yes 2 □ No 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe 1 ☐ Yes 2 🗹 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 21☑No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Mannet of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

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BRUNEY FRANCISCA JUN 0 5 2009

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b Signature and title of certifier

MD 29449 Charlotte Hall Road Charlotte Hall, MD 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar 29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 200 2010 M Ma Martin Drew Holland 4c. County of Dea 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death albo aston temoria If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) f Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number Hours Davs Months 1 M 2 □ F 82 05-22-1927 375-26-6921 MI. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h. County 10a State 1 ¥Yes 2 ☐ No Md. Talbot Easton 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 75 Parklane 21601 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Mes 2 ☐ If Yes, Give Year or Dates: 2 No 1 ☐ Yes 2 No Specify: Specify. White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) US Embassv Diplomat 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Keating, Esther Martin Α. Holland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Daug. Haghia- Sofia Holland 618 South Street, Easton, Md. 21601 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Direct Crematory
LLC 20c. Location - City or Town, State Crematory 06-05-09 Dover, Delaware 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Bennie Smith Funeral Home 21_Signature of Funeral Sirvice Licensee 426 Dover Street, Easton, Md. 21601 ahnn Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final bleed Intra Cerebral DAYS disease or condition resulting in death) Due to (or as a consequence of): ARACHNICO HEMORAAGE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \(\subseteq\) Nursing Home 5 \(\subseteq\) Residence 6 \(\subseteq\) Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 4 Homicide

Physician /Medical Examiner Examiner Physician/Medical

Physician

/Medical

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Funeral

Director

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Baltimore, Maryland 21215-0036

Funeral Director

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death certificate be executed burial-transi attending physician for use as the burial

Be Completed by

Certification: To

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

To the Hospital or Attending Physiclan; The law requires that the		To the Funeral Director: After this certificate has been signed by the	completely filled in by the funeral director, page 2 should be detached
Attending Physiclan:	r death.	ector: After this certific	by the funeral director,
To the Hospital or	within 24 hours after death.	To the Funeral Dir	completely filled in

Division of Vital Records, P.O. Box 68760,

RK 3+1VA

State Registrar

Ramehy 31. Date filed (Month, Day, Year)

MD

and manner stated

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

21601

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MAY 31 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) washington Street Easton 2195

32. Registrar's Signature

JUN 03 2009

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			For State	State of M	aryland		rtment of		and M		6.	2009	1965	53
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	Director		370-44-0332	I□M 2 % F 8	7	Yrs.	Wichitis Days	Hodis		02-18	-192	2 Gu	atemala	
	m w	}	Usual Residence of Decedent 10a, State 10b, County		10c. City.	Town or Loc	ation				-		10d. Inside City Lir	mits
	f sho	ō		ı	D	L							1 ☐ Yes 2 □] No
	the N 28a- notifi	Director	Md. Talbo 10e. Street and Number	Ε	Las	ton	10f. Zip Code				10g. Citize	en of What Co	ountry?	
	3a or	ID I	75 Park Lan	e			2160	1			US	A		
	death	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. V	Vas Decedent of Yes, specify Cul		gin? (Spe	cify Yes or No)- 14	1. Race - Ame Black, Whit	erican Indian,	
98	within 72 hours after death with the Maryland iene. than "natural", or items 23a or 28a-f show the Modicell Eveniner must be notified at		1 Never Married 2 Married	1 Yes 2			Yes 2□No		i, i dono i	nourt, otor)				
00	ural",	d by	3 Widowed 4 Divorced	Year or Dates:		16a Danas	ient's Hausi Ossu	nation.				d of Business	ispanic	
15-	n 72 l "nat	Completed	15. Decedent's E (Specify only highest gr	ade completed)		(Give	lent's Usual Occu kind of work done OO NOT use retin	durina most	t of workir	ng	TOD. KIIK	J OI BUSINESS	, madetry	
212	withi	i i	Elementary/Secondary (0-12)	College (1-4or	5+)	Se	cretary	7			US I	Embas	sy	
þ	filed II Hyg other	Be C	17. Father's Name (First, Middle, Las)					r's Name	(First, Middle	, Maiden S	urname)		
lar	uld be Aenta rked tic ev	To B	George B.	Soto				Нез	rcil	ia d	e Le	on		
lary	and I		19a. Informant's Name/Relationship	(Type. Print)			g Address (Stree							
Σ,	and and a ealth	1.5	Haghia-Sofia	Holland/			8 South	ı St.,						
Baltimore, Maryland 21215-0036	ges 1 t of H If itel		20a. Method of Disposition 1 ☐ Burial 2 ♣ Cremation 3 ☐	Removal from State	cer	meterv. cřen	sition (Name of natory or other pl	ace)	_	ate		ation - City or		
ţ	t. Pag tmen tant: njury		4☐Donation 5☐Other (Speci	fy)	DIL	LL	Cremato	JI Y , U) - 3 (J-09			laware _	_
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ira Modical Evaminer must be notified at once.		21. Signatura Funeral Shrvice Lice	nsee	ant	22	426 Do						eral Home 21601	е
			23a. Part 1. Enter the disease, or con shock, or heart failure. List only	plications that cause	d the death.	Do not ent	er the mode of dy	ring, such as	cardiac c	r respiratory	arrest,	V	Approximate Interval Between	
1	Physician	8 11	Immediate Cause (Final disease or condition		JA-LL	130	WEL	INF	ARC	TION			Onset and Deat DAYS	.n
أري	/Medical		resulting in death)	Due to (or as	a conseque									
	Examiner	<u>.</u>	Sequentially list conditions,	b. Due to (or as	0.00000000	noo of):								
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	D09 t0 (01 as	a conseque	since on).							ĺ	
	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as	s a conseque	ence of):								
8760,	te be ysicia e bur	dical		▲d										
9	rtifica ng ph as th	Medi	IS 55144 5	-								-		
Вох	eath certific attending p for use as	an/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregna	ncy			2	3d. Date of d	elivery Day Year	r
O.E	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant 9 ☐ Unknown	at time of de		Other (specify)					Month	Day 10a.	
σ.	that the de ned by the detached	P.	Part II. Other significant conditions	contributing to death	but not result	ting in the u	nderlying cause o	iven in Part I		23e. Did	tobacco us	se contribute	to the cause of death	h?
Division of Vital Records,	w requires that s been signed I s should be det	ξ	Diabele			ang ar are a	idenying sauce s	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		1 🗆	Yes 2]No 3□I	Probably 4 Onkr	nown
Sor	v requ	etec	Chronic	Obstru	thus.	Dul	MONEY	div	• 16	24a, Was	s an	24b. Were a	autopsy findings avai	ilable
Re	he law e has ige 2 t	Completed					1 122			auto peri	opsy formed?_	prior to death?	completion of caus	e of
tal	an: T tificat or, pa	a l	25. Was case referred to medical	F)				26. Place	e of Death	1 □Yes (Check only	one)	i in te	s 2 No	
>	Physician: r this certific ral director, p	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	tient 2 🗆 E	R/Outpatier	nt 3□ DOA O	thar:		me 5 ☐ Res		□Other (Sp	necify)	
0	ig Ph ter th	Ë	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of In	jury av. Year)	28b. Time o	28c. In W	jury at ork?		28d. Describe	how injury	occurred		
Sior	'Attending I er death. rector: After by the funer	atio	2 ☐ Accident investigation	on				□Yes 2□						
Ĭ	or Atter de after de Directe	Certification:	3 ☐ Suicide 6 ☐ Could not determined	28e. Place of Ir building, e	ijury - At hon etc. <i>(Specify)</i>	ne, farm, str)	eet, factory, office	9			(Street and own, State)		Rural Route Number,	1
Ω	oital ours at aral D		co. Continue de Continue D	huraialam. Ta tha haa	t of way lesson	iladaa daat	b accurred at the	time data a	nd place	and due to th	o canec(e)	and manner	as stated	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	29a. Certifier 1 ertifying F (Check only 2 Medical Exa	hysician: To the bes miner: On the basis and manners	of examinati	on and/or in	vestigation, in m	y opinion, dea	ath occur	red at the time	e, date and	place, and d	ue to the cause(s)	
	o the vithin o the	Mec	29b. Signature and title of certifier				29c. Lice	nse number			29d. Date	e signed (Mo	nth, Day, Year)	
	->=°		* KRame	m m	D		D	664	41		MAY	26	2009	
	3		30. Name and address of person who		death (Item	23a) (Type,	Print) INGTON			- A -	unanto a d	nnh	01601	
	7		KOLLI RAME	SH , 219	75 V	HZAG	INGTON	STR	JE ET	# EAS	STON,	שואו	21601	
	Sta		31. Date filed (Month, Day, Year)	2009 32. Regis	trar's Signatu	ure	backer							
	Registr	ar	INI & C	LUUY PEL		N. 17								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			State of Sta	Maryland / De	epartment of F Certificate of		Re	eg. No. 200	3 1300.
	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death	Day Yea	
	/Medic	al	Jean Cecelia Knight 4a. Facility Name (If not institution, give street and nur	nho r)	4h City Town o	r Location of Death	June 6,	4c. County of De	3:0/A
	Examin	er	St. Mary's Nursing Cent		Leonard			St. Mary	
	Funeral		Social Security Number 6. Sex.	7. Age (In yrs. last birtho	iay) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	I Q B	Airtholace (State or Foreign
	Director		577-20-1259 1□ M 2X F	87 Yrs	s. Months Days	Hours Min.	March 12	2, 1922 Pe	country) ennsylvania
	pu »		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	r Location				10d. Inside City Limits
	f sho	5	Maryland St. Mary's		nicsville				1 □ Yes 2X No
	the N	Director	10e. Street and Number	riechai	10f. Zip Code		1	0g. Citizen of What	Country?
	3a ol		26386 Woodridge Drive		20	0659		USA	
	death	Funeral	11. Marital Status 12. Was Dece	dent Ever in U.S.	13. Was Decedent of H	Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No-	14. Race - Ar Black, Wh	merican Indian,
5-0036	in 72 hours after death with the Maryland "natural", or items 23a or 28a-f show kadeni Evaninar must be notified at	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes ☐ Y	2. ZNNo ∕e	1 □Yes 2XNo			Specify:	White
5-0	72 hc	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. D	ecedent's Usual Occur Give kind of work done fe. DO NOT use retire	pation during most of work	king	16b. Kind of Busines	ss/Industry
121	filed within Hygiene. other than "	dmo	Elementary/Secondary (0-12) College (1	-40r 5+)	gal Technic			Federal Go	overnment
g 2	be filed valued Hygis d other event, II		17. Father's Name (First, Middle, Last)		,ar reemire		ne (First, Middle, M		3 V C I IIII C II C
au	thould be marked c matic eve	To Be	Arthur Brown			Helen I	Oolan		
Maryland	d 2 should the and Men 7 is marke traumatic	-	19a. Informant's Name/Relationship (Type. Print)	19b. M	Mailing Address (Street	and Number or Ru	ral Route Number	r, City or Town, State	e, Zip Code)
	and 2 ealth a n 27 is		Patricia Bauer/daughter		886 Woodrid	lge Drive	Mechani	icsville,	MD 20659
altimore,	es 1 of H fiter rott		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 3	cemetery,	isposition (Name of crematory or other pla	ce)	June 7,	20c. Location - City	
≣	t. Pages tment of tant: If it ijury or o		4 □ Donation 5 □ Other (Specify)	Brinsti	Le1d-Echo1s 22. Name and Addre	crem.	2000		Hall, MD
Ra	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee	3					11, MD 20622
ı			23a. Part 1. Enter the disease, or complications that c shock, or heart failure. List only one cause on e	aused the death. Do not ach line.	t enter the mode of dyi	ng, such as cardino	or respiratory arr	rest,	Approximate Interval Between Onset and Death
	Physician	8 1	Immediate Cause (Final disease or condition	TERM	unal	Cash	Efece	ر _	2013
	/Medical Examiner		resulting in death) Due to (or as a consequence of)	7		(1 . 0
		-e	Sequentially list conditions, if any leading to immediate	or as a consequence of	inne				41.
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events						
oʻ	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit			or as a consequence of)	:				
09/89	ate be hysici the bu	edical	d						
_	ertific ling p e as t	Mec	IF FEMALE:			- 77			
ROX	death cert le attendin ed for use a	Physician/M	in the past 12 months?	come of pregnancy pirth 2 Fetal death mant at time of death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	су		23d. Date of Month	Day Year
	the de	ysic	1 Yes 2 No 9 Unknown 9 Unknown		3 Other (specify)				
7, J	s that ned b deta	by Pr	Part II. Other significant conditions contributing to de	eath but not resulting in the	he underlying cause giv	ven in Part I.	23e. Did to	bacco use contribute	e to the cause of death?
ğ	quires en sig uld be				A ~~		1 🗆 Y	es 2□No 3□	Probably 4 Unknown
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ř	sician: The lav certificate has rector, page 2:	Som	. XX	/		,	perfor 1 □ Yes	med? death	n? ∕es 2□No
/Ita	cian: ertific	Be (25. Was c referent to medical examiner?		To.		th (Check only or	ne)	
0	Physi this c	၉	1 Yes 2 No No Nospital. 1 □	Inpatient 2 ER/Outp	atient 3 DOA		T	ence 6 Other (5	Specify)
5	ding I h. After funer	tion	1 Natural 5 Pending (Mon	th, Day, Year)	ury Wo	rk?]Yes 2 □No	26d. Describe in	ow injury occurred	
DIVISION	Atten r deat ector:	fica	3 ☐ Suicide 6 ☐ Could not be	of Injury - At home, farm			28f. Location (S	Street and Number of	r Rural Route Number,
É	al or safter	Certification:	4 Homicide determined buildi	ng, etc. (Specify)			City or Tow	m, State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Directors After this certification in the funeral director, it is completely filled in by the funeral director, it	Medical C	29a. Certifier (Check only one) 12 Certifying Physician: To the band in and man	e best of my knowledge, asis of examination and/ ner states.	death occurred at the to	time, date and place opinion, death occu	e, and due to the curred at the time, o	cause(s) and manne date and place, and	er as stated. due to the cause(s)
	To th within To th	Me	29b. Signature and title of dertifler	11 1	29c. Licen	se number	2	29d. Date signed (M	onth, Day, Year)
	_		b dayset a	NUE 101		0641	9	6-6-	09
			30. Name and address of person who completed caus	se of death (Item 23a) (T	ype, Print)	7			
			Dr. James Jarboe 240 31. Date filed (Month Day, Year) 33	35 Three No legistrar's Signature	tch Rd., H	ollywood,	MD 2063	36	
	Sta Registr		JUN () 8 2009	registral s Signature	Same				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend of Maryland 7 Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2009 Month **Physician** 5:30 a M June 10. Snellings Myrtle Virginia Kurz /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's St. Inigoes 48250 Waterview Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/26/1906 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 🛣 F Months Davs Virginia Director 225-92-7673 103 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, It a Mydical Examiner must be notified at 1 ☐ Yes 2 X No Director St. Mary's St. Inigoes Maryland | 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 2 and injury or other traumatic event, the Medical Examiner must he magnet. USA 20684 48250 Waterview Drive Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2★↑No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ∐Yes 2√TXNo Specify: \$ 3€Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Snellings Snellings Harry Tda ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 179, St. Inigoes, Maryland 20684 Judith Kurz Simmons/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/13/2009 | Fredericksburg, VA Oak Hill Cemetery 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle Simons 22955 Hollywood Rd., Leonardtown, MD 20650 M01206 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** cailme disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER Examiner Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Month Year in the past 12 menths? 1 ☐ Yes 2 ☑ No Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown this certificate has been si al director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? 1 \(\text{Yes} \) 2 \(\text{No} \) No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ₽ZING 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1- Natural 5 Pending investigation 1 ☐Yes 2x No 2 X Accident 4-22-09 11:59 pm subject fell within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 48250 Waterview Dr St. Inigoes, Md 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00062213 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

JUN U & STUR

Suresh Patel, M.D.

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records,

Box 68760

Baltimore, Maryland 21215-0036

22650 Cedar Lane Ct., Leonardtown, MD 20650

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MAY 26, 2009 830 A M ROBERT KEUFFEL KELLER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner EASTON TALBOT 28711 SPRINGFIELD DR. 8. Date of Birth (Month, Day, Year)
JUNE 1, 1918 If Under 1 Year If Under 24 Hrs. 5. Social Security Numbe 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Min Months 1**XX**1 2□ F NJ 055-16-7204 Yrs. 90 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at EASTON 1 ☐ Yes XX No TALBOT Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21601 USA 28711 SPRINGFIELD DR. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. XXYes 2 No If Yes, Give Year or Dates: 1944-45 1 Never Married 2 Narried Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: WHITE 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) VICE PRESIDENT SALES ulth and Mental Hygien 27 is marked other the traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be KARL KELLER GERTRUDE KEUFFEL ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a MARGARET KELLER WIFE Department of Health Important: If item 27 any injury or other tronce. 28711 SPRINGFIELD DR. EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial XX Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION 5-27-2009 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature | Funeral Service License 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL 200 S. HARRISON ST. EASTON, MD 21601 HOME, P.A. Approximate Interval Between Onset and Death 23a 241. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Myelodysplasia 17 ma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after clearh.

To the Funeral Lifect Ost. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlan-transit completely filled in by the funeral director, page 2 should be detached for use as the burlan-transit resulting in death) Last Due to (or as a consequence of) O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Ō. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐Yes 2 No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 □Yes 2 □ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

RK 12

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Halverson Down of 1 31. Date filed (Month, Day, Year)

30, Name and address of person who completed cause of deal (12 23a) (Type, Print)

1 Dr. Ste 301 Easten 8221 MD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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		For			State of	of Mar	yland						and M	lental H	ygien	e 🤈	009) 1	005
		State Registrar						(Cer	tificate	of L	Death			Reg. N	o. 📶	. 0 0 1	7 1	900
		1. Decedent's Name	e (First, Midd	le, Last)										2. Date of D Month		21/	Voor	3. Tim	e of Death
Physicia /Medic		Annie	L. Le	edou	X									May	30	21	00 ^{Year}	9:	40 A M
Examine		4a. Facility Name (i				ım <i>b</i> er)				4b. City, To			f Death		4	c. Cour	nty of Death		
/		Sunrise		kvil	le					Rock						Mon	tgomeı		
Funeral Director		5. Social Security N 224 03 0.	565	6. Sex] м 2[X F	7. Age (96	In yrs. la		rs.	If Under 1 Months	Year Days	If Under 2 Hours	Min.	8. Date of B 04/13	/191	3	9. Birth Nort	hace (Sta	te or Foreign
p		Usual Residence of						mg-									- T	los losta	- Oib - 1 / ib -
show	_	10a. State	10b. County			1	0c. City,												e City Limits
Ba-f s	Director	MD	Mont	gome	ry		Koc	ckvi	ГТТ (∕es 2⊠No
er 2		10e. Street and Nur	mber							10f. Zip C	ode				10g. C	itizen o	of What Cou	ntry?	
23a	<u>a</u>	8 Baltim	ore Roa	ad #	405					208	350				USA				
r dea	Funeral	11. Marital Status			12. Was Dec Armed F 1 ∐Yes	edent Eve	er in U.S.		13. W	as Deceder Yes, specify	nt of Hi y Cuba	spanic Ori n, Mexican	gin? (Sp , Puerto	ecify Yes or N Rican, etc.)	0-		lace - Ameri lack, White,		١,
or i	by F	1 Never Marr 3 Widowed			If Yes, G	ive			1	□Yes 2	∏No	Specify:				Spec	cify: Wh	ite	
hour tural	pa	3 E3 Wildowed	15. Deceder		Year or [Dates:	-	162 [Deced	ent's Usual	Occup	ation			16b	Kind of	Business/Ir	dustry	
n 72 "na erlic	Set		cify only highe	st grade	completed)		100	(Give k	ind of work O NOT use	done a	luring most	of work	ing		tina or	Dusinossin	ouddi y	
withi iene. thar	Completed	Elementary/Seco	ondary (0-12)		College (1-4or 5+)				eeper		,			R	ea1	Estat	:e	
filed Hyg other ent,	Be C	17. Father's Name	(First, Middle,	Last)	-							18. Mothe	r's Name	e (First, Middl	e, Maide	n Surn	ame)	-	
fenta fenta ked ic ev	P P	John Sh	elby L	ewis								Anni	ie G	ross Cl	har1	es			
shou and N s mai		19a. Informant's N	ame/Relations	ship (Typ	oe. Print)			19b.	Mailing	Address (Street a	and Numbe	r or Rur	al Route Num	ber, City	or Tov	vn, State, Zi	o Code)	
and 2 alth a 27 is		Ava L.	Healy/	Daug	hter			17	705:	3 Cata	a1pa	Ct/I)erw	ood MD	208	55			
of He of He item		20a. Method of Dis	•			_	cei	metery	. crem	ition (Name atory or oth	er placi	e)		Date	20c.	Locatio	n - City or T	own, State	9
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 □ Burial 2] 4 □ Donation			emoval from	State	Met	rop	oli	tán C	rem	átory	6/2	2/09	A1e	xan	dria	VA	
porti	İ	21. Signature of Fo	ineral Service	License	e /				22 A	Name and	Addres	s of Facility	y & C	rematio	on S	erv	ices		
8978		MAN	Mua	uce	X									d Anna					
		23a. Part 1. Enter t	the disease, o art failure. List	r compli	c ions that	caused th	e death.	Do no	ot ente	r the mode	of dyin	g, such as	cardiac	or respiratory	arrest,			Approxi Interval	mate Between
Physician		Immediate Cause disease or condition	(Final		0	Oim	n.in	Ti.	7									Onset a	ind Death UPAYS
/Medical		resulting in death)	511	€ a	Due to	(or as a c	onseque	ence of):										Jan
Examiner		Due to (or as a consequence of):																	
	Jer	Sequentially list co if any, leading to in	Sequentially list conditions, fany, leading to immediate Due to (or as a consequence of):																
cutec	Examiner	Cause (Disease or that initiated events	injury s	C													1		
e exe an ar rial-tr		resulting in death)	Last		Due to	(or as a c	conseque	ence of	·):						_				
eath certificate be executed attending physician and for use as the burial-transit	ca			d	l														
rtifica ng ph as th	Med	/F																	
th ce	Z Z	IF FEMALE: 23b. Was deceden		2	3c. If yes, ou	itcome of birth 2[pregnan	icy death	3 □	Ectopic pre	anancy	,					Date of deli	-	
e dea he att	Sicia	in the past 12 1 ☐ Yes 2 [No		4 □ Preg	gnant at tir	me of de	ath		Other (spec							Month	Day	Year
that the death certificate be executed ed by the attending physician and detached for use as the bunal-transit	Physician/Medical	9 🗆 Unknown																	
tha det	-	Part II. Other signi	ficant conditi	ons con	tributing to a	leath but r	not result	ting in t	the un	derlying cau	ise give	en in Part I.			tobacci	use co	ontribute to	ine cause	or death?

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Very the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlansit ompletely filled in by the funeral director, page 2 should be detached for use as the burla-transit

Medical Certification: To Be Completed by

Division of Vital Records, P.O. Box 68760,

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Tyes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No

25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 5 Pending investigation

26. Place of Death (Check only one) 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence

1 ∐ Yes

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) 29b. Signature and title of certifier

1 Yes 2 No

27. Manner of Death

2 Accident

3 Suicide

29a. Certifier

4 Homicide

29c. License number DØ461382

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

1 ☐ Yes

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14816 Physicians Lane # 152-Rockville, MD 20850 Śhama R. Mittal M.D.

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

31. Date filed (Month, Day, Year)

6 ☐ Could not be

determined



DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month atherine 8:20AM **Physician** /Medical Town, or Location of Death 4c. County of Death Facility Name (If not ipstitution, give street and number) 4b. City Examiner ber 6. Sex ince reverly Birthplace (State or Foreign Country) If Under 1 Year If Under 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 18-36-338 Min. 1 □ M 2 🕱 F Months Days Hours Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State show th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Expositor must be notified at Washing 1 Yes 2 □ No Directo ton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4011 Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) IMSING 17. Father's Name (First, Middle, Last) Be ဂ္ 19b. Mailing Address (Street and Number or Ru al Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a important: if item 27 is any injury or other tratonce. 50 ouse 4011 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Nation 2 ☐ Cremation 3 ☐ Removal from State ressiona 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Lone 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes Mellitus 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑No 24a. Was an Arterial Disease recipheral 1 ☐ Yes 2 No After this certification 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending nours after death. neral Director; Af illed in by the fur 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a Hospital 29a. Certifier 1 Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year) JUN 0 5 2009

29b. Signature and title of certifier

Uct avius

Toleted cause of death (Item 23a) (Type, Print) 1160 Varium POTK

29c. License number

00031941

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar AMFND#290perMD, 6/11/09, hMW, MOCO Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2009 **Physician** JANN LOFRANCE MARSHALL MAY 2200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MONTGOMERY Montgomery General Hospital Olney If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Ye July 15 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Maryland Months Days Hours Min 1 □ M 2 □ 53 ,1955 213-64-3845 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show r than "natural", or items 23a or 28a-f shorter Medical Expriner must be notified at MD Silver Spring 1 Yes 2 No Montgomery Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 14438 Bel Pre Road 20906 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black ò 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "na any injury or other traumatic event, Itel Table once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled None yr 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul G. Stanton Veronica D. Johnson ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Larry D. Marshall (Husband) 14438 Bel Pre Rd, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State France Family Cem 6/6/09 Cooksville, MD 4 ☐ Donajfon 5 ☐ Other (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signature f Funeral Service Lice 246 N. Washington St,Rockville,MD 20850 lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one Immediate Cause (Final MALNUTRITIO **Physician** YEAR disease or condition resulting in death) /Medical 5 YEARS **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 Other (specify) n signed by the a ld be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed peen . Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s performe certificate 1 ☐ Yes 2 ☐ No 1 □Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be

Box 68760, P.O. of Vital Records, Division

Maryland 21215-0036

Baltimore,

State Registrar DHMH 17 Rev 1/2001 3 Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier

determined

30. Name and address of person who completed cause of the ath (Item 23a) (Type, Print) HICLP OR #300 OLNEY, 31. Date filed (Month, Day, Year) 82. Registrar's Signature

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D35965

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day May 29 2009

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

For State Registrar

1. Decedent's Name (First, Middle, Last)

	Physici		1. Decedent's Name		DMAS		L	TILLEP		1	Month	30, 3	38 POOL
	/Medic Examir		A 4	f not institution	n, give street and number		1	4b. City, Town, C	ton	of Death	J	4c. Coun	
	Funeral Director		5. Social Security N		6. Sex • XX M 2☐ F	Age (In yrs. 73	last birthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of Birl (Month, Da AUG 18	y, Year)	9. Birthplace (S Country)
	land ow It		Usual Residence of 10a. State	Decedent 10b. County		10c. Cit	y, Town or Lo	ocation					10d. Insi
	Mary a-f sh	ctor	MD	TALBO	т	E	ASTON						1
	ith the	Director	10e. Street and Nu	mber				10f. Zip Code	01			10g. Citizen o	f What Country?
	ath w s 23a nust b		26304 н	ERONWOO	D RD.	nt Ever in II	C 13	Was Decedent of		rigin? (Spec	cify Yes or No		ace - American India
le r	-UU36 hours after death with the Maryland tural", or items 23a or 28a-f show at Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed		ried Armed Force 1 Tyes 2 If Yes, Give	es? OK lo		Was Decedent of If Yes, specify Cul			Rican, etc.)		lack, White, etc.
_	15-0036 72 hours afte "natural", or i	ted		15. Deceder	t's Education st grade completed)		16a. Dece	dent's Usual Occu	upation	st of workin	a	16b. Kind of	Business/Industry
2		Completed	Elementary/Seco		College (1-4	or 5+)	life.	DO NOT use retire R PRESID	ed)		3	BANK)	ENG
	Hygier ther th	S	17. Father's Name	(First, Middle,	· ·		VIC	II I KUDID		er's Name	(First, Middle	, Maiden Surn	ame)
5	vre, Maryland 2121 s 1 and 2 should be filed within of Health and Mental Hyglene. item 27 is marked other than other traumatic event, In a Ma	To Be	JOHN MILI						CHA	RLOTT	E MART	IN	
Ĕ	ary shoul and M s mar	-	19a. Informant's N	lame/Relations	ship (Type. Print)								vn, State, Zip Code)
noma	Te, M 1 and 2 Health em 27 i		PATRICIA		WIFE	1001	_	4 HERONW			STON,		n - City or Town, Sta
<u>ـــــ</u>	Baltimore, permit. Pages 1 ar Department of Hea Important: If item 3 any injury or other once.		20a. Method of Dis XXBurial 2 4 □ Donation	Cremation	3 □ Removal from Sta Specify)	ate	TORD (osition (Name of matory or other pl		06-04	-2009	OXFO	RD , MD
	Balti Dermit. Departn Importa any infu		21. Signature of F	uneral Service	Licensee		\ \\ \\ \ \ \ \ \ \ \ \ \ \ \	2. Name and Add FELLOWS, 200 S. HA	ress of Facil	NBEIN	& NEW	NAM FUI	NERAL HOM
	Physician /Medical Examiner nial-transit	l Examiner	shock, or he Immediate Cause disease or condition resulting in death) Sequentially list or if any, leading to ir cause. Enter Und Cause (Disease or that initiated event resulting in death)	art failure. Lis	b. Due to (or		SCLEYA quence of): quence of):	one ar					Appre Interv Onse
	P.O. Box 68760, at the death certificate be executed by the attending physician and etached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was deceder in the past 1: 1 ☐ Yes 2 9 ☐ Unknow	2 months? □No n	4 ☐ Pregna 9 ☐ Unknow	th 2□Fet int at time of wn	al death 3 death 5	☐ Ectopic pregna☐ Other (specify)			23o Did		Date of delivery Month Day
	cords, P.O. w requires that the d sbeen signed by the should be detached	ğ	Part II. Other sign	ificant condit	ions contributing to dea	th but not re	sulting in the	underlying cause	given in Pari				o 3 Probably
	Reco	Completed									24a. Wa: auto peri 1 🗌 Yes	s an 24 opsy formed? 2 2 No	4b. Were autopsy fir prior to complete death? 1 \(\text{Yes} \) 2 \(\text{I} \)
	Vital Fidician; The certificate	Be C	25. Was case refe examiner?	erred to medica						ce of Death	(Check only	one)	
	on of ding Phys	ျ	1 Yes 2 27. Manner of Dec 1 Natural 2 Accident	ath 5 □ Pendi inves	28a. Date of (Month tigation		ER/Outpati 28b. Time Injury	of 28c. Ir	Other: 4 1 I njury at vork? Yes 2			sidence 6 🗆 e how injury oc	Other (Specify)
	Divisio To the Hospital or Attend within 24 hours after death To the Funeral Director: /	Certification:	3 ☐ Suicide 4 ☐ Homicide		mined 200. Flace of building	g, etc. (Spec	лі <i>у)</i> 	street, factory, office			City or To	own, State)	umber or Rural Rou
	the Hospital hin 24 hours a the Funeral I	Medical	29a. Certifier (Check only one)	2 Medica	ing Physician: To the ball Examiner: On the ball and mann	sis of examir	nowledge, de nation and/or	investigation, in m	e time, date ny opinion, d ense numbe	leath occur	and due to the	e, date and pia	ace, and due to the designed (Month, Day,
	12 with 12 mo	2	29b. Signature an	na title of ertifi	er _ / /)		29G. LIG	onae numbe				/ / 00

c. Location - City or Town, State OXFORD , MD M FUNERAL HOME, P.A. MD 21601 Approximate Interval Between Onset and Death HE cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami Due to (or as a consequence of): Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 Wunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my original death and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mariner and the cause(s) and mariner and mariner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of 20057908 hut Mushin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death

183a

 Birthplace (State or Foreign Country) NY

> 10d. Inside City Limits 1 Yes XX No

14. Race - American Indian, Black, White, etc. Specify: WHITE

ST MICHABLY MD

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) **3 2009**

RK15

32. Redistrar's Signature

8805. TALBOT ST

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Beaufort 2009 13 35 AM Reato /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Prince Georges Community Hospital cheverly If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Min 578-36-7349 1 □ M **9** F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Prince Georges 1 Nes 2 No MD Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 5302 N. Englewood Drive 20785 USA Items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 To Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 □Yes 2 Ho If Yes, Give Year or Dates: Specify: Specify: Black Completed by Widowed 4 ☐ Divorced Department of Health and Mental Hygiene. important: If item 27 is marked other than 'natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ROSSER Plummer ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5302 N. Englewood DR. Hyatts ville, MD 20785 Katie Davis 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Surial 2 ☐ Cremation 3 ☐ Removal from State Brentwood, mb Fort-Lincoln Cemetery: 6-8-09 4 Donation 5 Dother (Specify) 21. Signature of Funeral ST NW Wash, DC 20011 Approximate Interval Between Onset and Death 23a. Part 1. Enter the diseas shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, s st only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical **iF FEMALE** 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Tes 2 **X** No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an 1 ☐Yes 2 🗷 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

CR-3

State Registrar

31. Date filed (Month, Day, Year)
JUN 0 5 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

060096

HOSPITAL DR.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month **Physician** 6:10 P[™] May 2009 31 James Albert Middleton /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Silver Spring
If Under 1 Year | If Under 24 Hrs.
Months Days | Hours | Min. Holy Cross Hospital Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months 1**X** M 2□ F \mathbb{C} July 2, 1937 71 Director 577-52-9920 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Middle Earn is the notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County DC 1XYes 2 □ No Washington Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20018 USA 3298 Fort Lincoln Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 1955— If Yes, Give Year or Dates: 1958 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify Specify: Black 5 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Security Officer Security 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Middleton Unknown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3922 24th Ave., Temple Hills, MD 20748 Donna M. Middleton / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Triangle, VA 4 Donation 5 DOther (Specify) Quantico National :06/11/09 22. Name and Address of Facility Bell and Johnson Funeral Home, P. A. 21. Sign of e of Funeral Service License Unnsc HIGHT 6503 Old Branch Ave., Temple Hills, MD 20748 23a. Part 1. Enter the disease, or compact tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nor k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Multiorgan failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed Acute Cerebrovascular Accident attending physician and for use as the burial-tran Due to (or as a consequence of) Records, P.O. Box 68760. Physician/Medical Hypernetremia IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 1 □Yes 2 □No 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Thrombocytopenia Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Anemia autopsy performed? 1 □ Yes 2 🔊 No 1 ☐Yes 2 🕅 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation r death. 2 Accident after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital of within 24 hours at To the Funeral D 1 K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

31. Date filed (Month, Day, State JUN 0 5 2009 Registrar

29b. Signature and title of cert

Dr. Delroy Anglin 1500 Forest Glen Road, Silver Spring, MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D55148

29d. Date signed (Month, Day, Year)

May 31, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Mary	•	artment of F rtificate of .			0.0	0.0	10001
			Registrar 1. Decedent's Name (First, Middle, La	ast)			Death	2. Date of Deat	e g. No.	UJ	3. Time of Death
	Physicia		Marian		McAdoo			Month May	27, 20	Year	14:51 P ^M
	/Medio Examin		4a. Facility Name (If not institution, given	ve street and number)	HCAGOO	4b. City, Town, o	r Location of Death	1100)	4c. Count		1-1.01
		er	P.G. Community H			Chever	-1 v		Princ	ce Geo	rges
	Funeral		5. Social Security Number 6.	Sex 7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,			ace (State or Foreign
	Director		577-44-8001	1□M 2反F	80 Yrs.	Months Days	Hours Will.	09/16/1	928		rd, NC
	pu ,		Usual Residence of Decedent	10	c. City, Town or Lo	postion				10	Od. Inside City Limits
	aryla shov	<u>_</u>	10a. State 10b. County Prince		Bowie	Callott					1 ☑ Yes 2 ☐ No
	he M	ect	10e. Street and Number	Georges	DOMTE	10f. Zip Code		1	0g. Citizen of	What Coun	trv?
	a or	ä	12305 Tilbury La	ne		207	15		USA		•
	ns 23	era	11. Marital Status	12. Was Decedent Ever	in U.S. 13.		Hispanic Orlgin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Ra	ce - Americ	
0	fter d riter	Funeral Director	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 □Yes 2 ☑ No				Rican, etc.)		ick, White, 6	_
50	al",o	ρ	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ∐Yes 2 🔀 No	Specify:		Speci	ty: Bla	ick
2	72 ho	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give	dent's Usual Occup	during most of work		16b. Kind of E	Business/Inc	lustry
21215-0036	ithin han "	ld m	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire	d)		0.		
N	lled w Hygie ther t		17. Father's Name (First, Middle, Las	4yrs	Te	acher	18. Mother's Nam	e (First, Middle, I		overnn me)	lent
ang	should be filed within 72 hours after death with the Maryland and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show umatic event, it as Modical Exert it are must be regifted at	Be c	Laurie Wil		on Sr.		Edith	Lanca		,	
Ž	hould nd Me mark matic	ပ္	19a. Informant's Name/Relationship			na Address (Street	and Number or Rui			n, State, Zip	Code)
e ≥	nd 2 s Ith ar 27 is rtrau		Evelyn McAdoo/ D		V 4		Lane, Bo				
ō,	f Hear frem tem		20a. Method of Disposition			osition (Name of matory or other pla			20c. Location	- City or To	wn, State
Ë	Page: ent o nt: f		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of Cont	→ Hemoval from State 6	Quantico	National	Cem 6/08	/2009	riangl	e, Vi	rginia
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It is Margal Exa., it is it in the Example 2 and once.		21. Signature of Funeral Service Dice		2	2. Name and Addre	ess of Facility Jo	hnson &	Jenki	ıs Fur	eral Home
ñ	Departing Department of the Sun o				2.	716 Kenne	dy St. N	, Washi	ngton,	DC 2	20011
П			23a. Part 1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the	death. Do not en	ter the mode of dyi	ng, such as cardiac	or respiratory arr	rest,		Approximate Interval Between
30	Physician		Immediate Cause (Final disease or condition		c Arryth	พาส					Onset and Death
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ot	ding Physician: The h. After this certificate h funeral director, page	은	1 Yes 2 No 27. Manner of Death	1 Inpatient	2 X ER/Outpatie	ent 3 L DOA	4 □ Nursing H	ome 5 Resid			fy)
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<u>></u>	i Sire	Certification: To	4 Homicide determine	building, etc. (S	Specify)			City or Tow	ın, State)		
_	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying F	Physician: To the best of m	ny knowledge, dea	th occurred at the	time, date and place	e, and due to the	cause(s) and	manner as	stated.
	he Hc in 24 he Fu pletel	Medical	(Check only 2☐ Medical Exa	aminer: On the basis of ex and manner stated	arnination and/or i	rivestigation, in my	opinion, death occu				
	Vithi Vithi Comp	Ž	29b. Signature and title of certifier	70		29c. Licen	se number	_	29d. Date sign	ned (Month,	Day, Year)
			abells	Mars	4	D	2757	7	5/2	91	109
0	2			o completed cause of death			4	00705		/	
	~		Ophnell Cumberb 31. Date filed (Month, Day, Year)				eriy, MD	20/85			
	Sta Registi		JUN 0 5 2009	Men D.	Signature	•					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Physician		legistrar 1. Decedent's Name (First, Midd	le,Last)							2	Date of Dea				3. Time of Death
Medical Examine	er	Santos Leonel					- 0'1 T				June 2, 2		Year County of	Dooth	1120 hrs
		4a. Facility Name (if not institution 1410 University Boule	· -	number)			b. City, Tow Hyattsvi		ocation of	Deam			rince Ge		s
Funeral		5. Social Security Number	6. Sex	7. Age (In			If Under 1	Year	If Under 2	24Hrs. Min.	1			Cou	nplace (State or Foreign ntry)
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b.	_	Usual Residence of Decedent 10a. State 10b. County		100	City To	wn or Locati	าก		_					- 1	10d. Inside City Limits
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Maryland 28a-f show d at nnce.	DILECTOR	10e, Street and Number					10f. Zip Co	de	-			-	en of Wha		iry?
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ath wit	runeral	11. Marital Status 1 Never Married 2 😠 M	larried Armed	ecedent Ever Forces?			s Decedent on es, specify C				cify Yes or No tican, etc.)	0-	14. Race - White,		an Indian, Black,
fter der 17°, or i	בו		/orced If Yes, Give \ or Dates:	ear 2 X	No	1 X	Yes 2	No	specify: H	lond	uras],	Specify:	His	spanic
ours a	<u> </u>	15. Decedent's Education (Spe	ecify only highest g	•	ed) 16	6a. Deceden	's Usual Oc					16b. K	ind of Busi	ness/In	dustry
36 in 72 h han "n	Сошріете	Elementary/Secondary (0-12) 9th	College	(1-4 or 5+)		Labor		3			-,	C	onsti	uct	ion
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be files antal Hy rrked o	e e	Eriberto Ram	os						S-3		a Nune				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoulingury or other traumatic event, the Medical Examiner must be notified at nace.	2	19a. Informant's Name/Relations Rosa Maria Pa		fe							iral Route Nu 02, Hy				Zip Code) Id 20783
Te, No. 1 and 1 Health Fitem		20a. Method of Disposition 1 X Burial 2 Cremation	n 3 Pomova			ce of Dispos matory or oth		of ceme	etery,		Date		ocation - (City or	Town, State
Pages nent of sant: 1		4 Donation 5 Other S	pecify:	THOM OLATE	Ge	neral					/10/09		Hondı		
Balt Permit. Departi	1	Signature of Funeral Service	Lice								ash. D			iera	1 Home
Physician	+	3a. Part I. Enter the disease, or		t caused the	death. D	o not enter th	ne mode of o	lying, s	uch as car	diac or	respiratory ar	rest, sho	ck, or hear	t	Approximate Interval Between Onset and
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F	- 1	or condition resulting in death)	Due to (or a	s a conseque	nce of):										
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68760 certificate Inding phys		IF FEMALE: 23b. Was decedent pregnant in t	ho 🗔	s, outcome of e birth	f pregnai		tal death	3	Ectopic p	pregnan	icy	230	 Date of of Month 		yay Year
Box 6876 e death certificate the attending phy ed for use as the 1	Physician/M	past 12 months? 1 Yes 2 No 9 Ur	4 Pre	egnant at time	of death	<u>, -</u> =	her (Specify	')							
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rds, requir	<u>ĕ</u>										24a. Wa:				topsy findings available ompletion of cause of
eco he law ate has	Completed											ormed?		eath? ✔ Ye	s 2 No
Pala R	Be .	25. Was case referred to medic					26.		of Death (C	Check o	nly one)				
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Division of Vital Records, P.O. 1st or Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.		27. Manner of Death 1 Natural 5 Per	ndina FOÜİ	ate of Injury onth, Day, Year) ND:	F	8b. Time of I			at Work? es 2 ✓ I	ļ.	Subject ha			u	
r Atter ter deat irector n by th	Certification:	= -	Jouganon	2, 2009 lace of Injury		1110 hrs ne, farm, stre	et, factory, o	ffice bu	uilding, etc.				nd Numbe	r or Ru	ral Route Number, City
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Division of Vital Rec Tn the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate b completely filled in by the funeral director, page	Medical		Physician: To the aminer: On the bas	is of examina											
The wit	Me	29b. Signature and title of certif	and manne ier	er stated.			29c. L	icense	number			29d.	Date signe	d (Moi	nth, Day, Year)
		Carrol	Hall	de			(D.C.N	И.E.			Jun	e 3, 200	9	
R 2	ļ	30. Name and address of perso Carol Allan, MD As	n who completed o			^{3a)} 11 Penn :	Street, Ba	altimo	re, MD	21201	ĺ				
Sta	te	31. Date filed (Month, Day Year)		Registrar's S	ignature										
Registr	ar	JOH D 5 5003	Leneva	g.	4944	1									

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician

/Medical

Examiner

Funeral Director

Completed by

Be

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Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.

ant; If item 27 is marked other than "natural", or items 23a or 28a-f show

rry or other traumatic event, If a Medical Examinations is invited at

Department of Important: If it any injury or conce.

Baltimore, Maryland 21215-0036

	Edward N. Brins	hart was		Hollywood Ro					
)r	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Myocardial Infarction								
	resulting in death)	Due to (or as a consequent b. Coronary Art Due to (or as a consequent	7 years						
Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequen	Hypertension Due to (or as a consequence of):						
lica		d. <u>Tobacco Addi</u>		10 years					
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □Unknown		1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)						
ed by Phy	Part II. Other significant conditions of Hyperlipidemia		ute to the cause of death? Probably 4 Unknown						
plete	Peripheral Vascu	24b. Were a	e autopsy findings available to completion of cause of						
Com	Squamous Cell Ca	ncer of Head/Ne		death? lo 1 ☐ Ye	ith?]Yes 2 □No				
Be Co	25. Was case referred to medical examiner?			26. Place of Death (Check only one)					
	1∐Yes 2⋤No	Hospital: 1 ☐ Inpatient 2 ☐ EF		Other: 4 Nursing Ho	me 5xxResidence	Residence 6 ☐ Other (Specify)			
Medical Certification: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Bb. Time of lnjury M	. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how inj	ury occurred			
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, o	ffice	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ate)			
	29a. Certifier 1 * ertifying Phrone) 1 Medical Example 2 Medical Example 2	ysician: To the best of my knowled niner: On the basis of examination and manner stated.	edge, death occurred at n and/or investigation, in	the time, date and place, my opinion, death occurr	and due to the cause red at the time, date a	(s) and manner nd place, and di	as stated. ue to the cause(s)		
Me	29b. Signature and title of gertifler	9		00060210	29d. C	Date signed (Mo	nth, Day, Year)		

DHMH 17 Rev 1/2001

State Registrar 24035 Three Notch Road, Hollywood, MD 20636

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Amish Shah, M.D.

31. Date filed (Month, Day, Year)

Physician /Medical Examiner For State Registrar

Funeral Director

2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evanther must be notified at once. Pages 1 and 2 s ment of Health ar

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Box 68760. P.O. After this certificate has been signed by funeral director, page 2 should be detacl Division of Vital Records, this death. To the Hospital or Attend within 24 hours after death To the Funeral Director: filled in by

Funeral Director 10200 Sassafras Woods Court 22015 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+Nurse 17. Father's Name (First, Middle, Last) Be Palabrica Pacita Μ. ဥ Jesus 19a. Informant's Name/Relationship (Type. Print) Arlene P. Little / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Lincoln Crematory 6/01/2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Aureral Service Dicensee complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part 1. Enter the disease of shock, or neart failure. List Immediate Cause (Final disease or condition resulting in death) METASTATIC BREAST CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 UnknownX Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 24a. Was an autopsy 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) æ Hospital: 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 X Natural 5 Pending investigation 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier

1. Decedent's Name (First, Middle, Last) 3. Time of Death Year MAY 21 2009 8:35 CARMELITA PALABRICA PINEDA 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death MONTGOMERY CENTER BETHESDA If Under 1 Year | If Under 24 Hrs. NATTONAL NAVAL MEDICAL.

5. Social Security Number 6. Sex 7 Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Sept. 12, 1 Age (In yrs. last birthday) Days Hours 1 □ M 2 🖾 F Months 259-27-7787 57 1951 Philippines Sept. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 1X Yes 2 No Virginia Fairfax Burke 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Untied States 14. Race - American Indian, Black, White, etc. Specify: Filipino 16b. Kind of Business/Industry Nursing 18. Mother's Name (First, Middle, Maiden Surname) de Jesus 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7729 Hiawatha Lane; Derwood, MD 20855 20c. Location - City or Town, State Brentwood, MD 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, MD 20852 23d. Date of delivery Month Dav 23e Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐Yes 2 ☐ No 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature a 010105 3645 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATHONAL NAVALINEDISCOL KENNETH MORE CDR MC USN 32 Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 03

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar	State of	wai yian		rtmen <i>tificat</i>			and ivi	ental Hyو ا	giene Reg. No. 🤈 [000	1065
	Physicia	ın	1. Decedent's Name (First, Middle, Last) Joseph William Paolillo				Mo			Month Day Year			3. Time of Death 6:05 A	
	/Medic Examin	er	4a. Facility Name (If not institution ST. Mary s Hos	, give street and num			Le	onar	dtown	of Death		4c. Count	Mary	's
	Funeral Director		5. Social Security Number 086-34-5006 Usual Residence of Decedent	6. Sex 1 M 2 □ F	7. Age (In yrs. I	ast birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	Min	8. Date of Birt (Month, Da ugust	h y, Year) 26,1941	Coui	lace (State or Foreign try) York
backack od	28a-f show	ctor	10a. State 10b. County	Mary's		, Town or Loc						10g. Citizen of		0d. Inside City Limits 1 ☐ Yes 2 🛣 No
di.ii	3a or		40135 Beach Dr	ive			10 2.1	20659 US						,
Glod within 70 hours offer dooth with the Mandand	marked other than "natural", or items 23a or 28a-f show matic event, it w. M. diral Evaning must be notified at	by Fu	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorced 15. Decedent	Armed For To Yes If Yes, Giv Year or Da	re	16a. Deced	□Yes dent's Usu	2 XNo	Specify:		cify Yes or No Rican, etc.)	Speci		etc. White
Mai yiaiiu zizi;	/giene. er than "r , the Med	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)	life. L	nter_	se retired)						of Defense
2 10 E	e d al	To Be (17. Father's Name (First, Middle, Domonic Paolil	*							(First, Middle,	Maiden Surna ecca	me)	
	is	_	19a. Informant's Name/Relationsl Rita Paolillo									er, City or Town		
allinior, n			20a. Method of Disposition 1 ☐ Burial 2X Cremation 4 ☐ Donation 5 ☐ Other (S)		State I	lace of Dispo emetery, cren insfie				Tu	ne 4,	20c. Location		all, MD
i di	Department of Important: If any Injury or once.		21. Signature of Funeral Service		JII.	22	. Name a	nd Addres	s of Facilit	ty Brin		-Echols	F.H.	, P.A., , MD 20622
	nysician		23a. Part 1. Enter the deease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	complications that conly one cause on e	aused the death ach line.	n. Do not ent	_		g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
	/Medical xaminer		Due to (or as a consequence of): EN CEMAL b. EN CEMAL					44						HOURS.
politod	and transit	Examine	is any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): LIVER FA Due to (or as a consequence of): LIVER FA C. Due to (or as a consequence of):				-UR-E							Days
cate be executed	ohysician and the burial-transit	dical					E LIVER METAST					FA STS	19573 MONTHS	
The lower requirements of the contract of the	by the attending particular for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, out 1 Live t 4 Preg 9 Unkn		Ectopic pregnancy Other (specify)				23d. Date of delivery Month Day Year				
toda opinio	been signed by	b	Part II. Other significant condition	II. Other significant conditions contributing to death but not resulting in the underlying caus					en in Part I	l.	23e. Did tobacco use contribute to the caus 1 ☐ Yes 2 ☐ No 3 ☐ Probably			
ioion: The law requires #	certificate has berector, page 2 sho	Completed									1 □ Yes	psy prmed? 2 1 No		opsy findings availabl ompletion of cause of 2 No
dicio	is certific director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	mpatient 2 □	ER/Outpatier	nt 3 □ D	26. Place of Death (Check only one) 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)						
or Attending Day	th. : After thi e funeral o	tion: T	7. Manner of Death 1											
A 440	within 24 hours after death. To the Funeral Director: After this certification of the funeral director, it is completely filled in by the funeral director, it is completely filled in by the funeral director, it is completely filled in by the funeral director, it is completely filled in by the funeral director, it is completely filled in by the funeral director, it is completely filled in by the funeral director, it is completely filled in by the funeral director.	Certification: To	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)				eet, factor	1 ctory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)						
. Hoopit	within 24 hours To the Funera	Medical C	29a. Certifier 1 ertifyir (Check only one) 2 Medical	ng Physician: To the Examiner: On the b and man	best of my kno asis of examina ner stated.	owledge, deat ation and/or in	h occurred	at the tir	ne, date a pinion, de	and place, eath occur	and due to the	e cause(s) and , date and plac	manner as e, and due	stated. to the cause(s)
¥ 4	To th comp	Me	29b. Signature and title of certifie	v,	n	10	29		e number	6		29d. Date sign	ned (Month	
F	Ya		30. Name and address of person	who completed caus	se of death (Iter	n 23a) (Type,	Print)	,	1					-
	1		Dr. Rajbind	ler S. Gil	1, 2403 Refistrar's Signa	5 Thre	e No	ch F	Rd.,	Holly	wood,	MD 2063	36	

DHMH 17 Rev 1/2001

Joseph William Paolillo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 00 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** George Pappas, Jr. 06 12 09 0210 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany WMHS Braddock Campus Cumberland 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Year) Months Days Hours 88 215-14-2966 Maryland 1921 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 ☐ Yes 2 No Garrett MD SWANTON 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hydene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be none. U.S.A. 505 Beckman Peninsula Road 21561 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? 1

Yes 2

No Black, White, etc. 1942 1 MYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🗹 No Specify 2 1946 3 K Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Owner / Operator Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leona Horn Pappas Johnson ပ George Pappas, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 82 Meadow Road, Frostburg, MD 21532 George W. Pappas 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 06-15-2009 Frostburg Mem Park Frostburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sowers funeral Home, FRostburg, MD 21532 1100547 Hon 60 W. Main St 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive 2 weeks /Medical Due to (s a consequence of): Examiner Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of): Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 9 Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this contract of the Funeral Director: After this contract of the Funeral Director. sician and burial-transit burs after death.

eral Director: After this certificate has been signed by the attending physician filled in by the funeral director, page 2 should be detached for use as the buria

the Maryland

Baltimore, Maryland 21215-0036

ns 23a or 28a-f show

Certification: To

5 Pending investigation

6 ☐ Could not be 3 Suicide determined 4 Homicide 29a. Certifier

29b. Signature and title of certifier

(Check only one)

🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

00055325

29d. Date signed (Month, Day, Year)

June 12, 2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

· worrockstu MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bishop Walsh Rd. Cumberland, MO 21502 WONSOCK SHIN 925

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

Medical

31. Date filed (Month, Day, Year) JUN 18 2009 32. Registrar's Signature

Box 68760. Ö ۵. of Vital Records, Division

To the Funaral Director: / within 24 hours a

Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37934 June 1, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20770 Stephanie Trifoglio, MD 7500 Greenway Center Dr. #430 Greenbelt, MD 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar JUN U 4 2009 ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Depedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician /Medical ity Name (If not institution, give street and number) 4b. Sty, Town, or Location of Death County of Death **Examiner** Kock Jalley Dusk Home ville Montsomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Year) 1930 Canada 1 X M 2 □ F Months Days Hours Min Director 459-36-4140 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature."" 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 XNo Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 3210 N. Leisure World Blvd. #212 20906 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 XYes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1 □Yes 2 No If Yes, Give Year or Dates: 1954–56 Completed by Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Salesman Kitchen Design 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lillian Rosener Barney Rubin 70 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 4212 Silver Spring, MD 19a. Informant's Name/Relationship (Type. Print) 3210 N. Leisure World Blvd #212 Silver Spring, Sandra R. Rubin/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Final Journey Crematory 06/05/09 Woodbine, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License Colingation Service Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the decase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** re-ex meumonia disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by ncephalopating 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Bipolar 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Buchosi 1 ∐Yes 1 ∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled i turse practitioner 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

E-{-

DHMH 17 Rev 1/2001

Registrar

4

Juite tol

30. Name and address of person who completed cause of death (Item 23a) (Type, Printy MARY HAINES, CRNP

Registrar's Signature

1 - For State Registrar

	Physic		Madaline Smith						Month May		Year 340 P M
- May	/Medi Examii		4a. Facility Name (If not institution				4b. City, Town, o	r Location of D	eath	4c. County	
			Montgomery Ger				Olney If Under 1 Year	If Under 24	Hre O Data - 4 F		gomery
	Funeral Director		5. Social Security Number 578 - 86 - 3649	6. Sex 1 □ M 2 X F	7. Age (In yrs. i		Months Days		Min. August	O4,1924	9. Birthplace (State or Foreign Country) North Carolin
	and w		Usual Residence of Decedent 10a. State 10b. County	/	10c. City	y, Town or Lo	cation				10d. Inside City Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evaninal his notified at sone.	ioi		gomery		lver Sj					1 ☐ Yes 2X No
	or 28g	Director	10e. Street and Number	, J			10f. Zip Code			10g. Citizen of W	hat Country?
	23a c	la I	2601 Bel Pre F				20906			United	
	er deg	Funeral	11. Marital Status 1X Never Married 2□ Ma	Armed For	dent Ever in U. ces?	S. 13. \	Was Decedent of F f Yes, specify Cub	lispanic Origin an, Mexican, P	? (Specify Yes or I uerto Rican, etc.)	No- 14. Race Black	e - American Indian, k, White, etc.
036	urs aft		3 ☐ Widowed 4 ☐ Divorce	If Yes Giv	e		1⊡Yes Z∏No	Specify:		Specify.	Black
2-0	72 hou	Completed by	15. Decede	nt's Education est grade completed)		16a. Deced	dent's Usual Occup	ation	working	16b. Kind of Bu	siness/Industry
121	ithin 7 ne. han "	apd m	Elementary/Secondary (0-12)	College (1-	4or 5+)	life. L	DO NOT use retire	d)	Working	Unkn	oum
12	filed within Hygiene. other than '		Unknown 17. Father's Name (First, Middle	(ast)			Unknown	18 Mother's	Name (First, Midd	le, Maiden Surnam	
Baltimore, Maryland 21215-0036	should be fi and Mental B s marked of umatic ever	To Be	Unobtainable	-					btainable		-7
ary	2 shou and N is mai	-	19a. Informant's Name/Relation	ship (Type. Print)						nber, City or Town,	
Σ,	and 2 ealth m 27 i		Sherry Davis	s, Guardiar							ville, MD 2085
lore	ges 1 nt of H if ite or otl		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		sale i		sition (Name of natory or other plac		Date		City or Town, State
Itim	permit. Pages 1 Department of I Important: If ite any Injury or ot	Ш	4 Donation 5 Other (For		oln Crema			1	od, Maryland
Ba	Depa Impo any li		21. Signature of Funeral Service	Licensee			2. Name and Addre			ribuute ckville,	MD 20850
			23a. Part1. Eyler the dise 15. c shock, or heart failure is	or complications that ca	used the death						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	tonly one cause on each O_{Λ} /	G 1111	ALLA					Onset and Death
	/Medical		resulting in death)	Due to (c	or as a consequ	uence of):					9,7,5
1.0	Examiner	_	Sequentially list conditions,	b							
K	uted I insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		or as a consequ	derice or).					
ć	execu in and ial-tra	Exa	that initiated events resulting in death) Last	CDue to (c	or as a consequ	uence of):					
Box 68760,	death certificate be executed e attending physician and d for use as the burial-transit	lical		d							
9 X	eath certific attending p for use as	sician/Medical	IF FEMALE:	23c. If yes, outo	ome of pregna	incv				and Dat	e of delivery
B	ed for u	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live b 4 ☐ Pregn	irth 2☐ Feta ant at time of d	Ideath 3□	☐ Ectopic pregnand ☐ Other (specify) _	у		Mo	The second secon
P.O.		Phys	9 ☐ Unknown	9 ☐ Unkno	own						
	es tha	5	Part II. Other significant condit	ions contributing to de	ath but not resu	ulting in the ur	nderlying cause giv	ren in Part I.			ibute to the cause of death?
oro	w requires been signal	sted	HYVERIEUSIC	DIHIO	EIES	IDEN	ACNTIFI.	CHE			3 Probably 4 ☐ Unknown
of Vital Records	has the	Completed	CVA, PVD	PAKKI	NSONS	D1	SEASE-		24a. Wa	as an 24b. V topsy rformed?	Vere autopsy findings available prior to completion of cause of leath?
Ta	sician; The k certificate ha rector, page 2		25. Was case referred to medical	21				00 Diago of	1 □ Yes	2 110 1	☐Yes 2☐No
<u> </u>	ysician; is certific director,	To Be	examiner?	Hospital:	patient 2	ER/Outpatier	nt 3 🗆 DOA Oth	or:	Death (Check only	esidence 6 Oth	er (Specify)
n of	ding Phys h. After this funeral di		27. Manner of Death 1 □ Natural 5 □ Pendi	28a. Date o		28b. Time of		ry at	<u> </u>	e how injury occurr	. , , , ,
Sio	leath.	catic		igation			M 1□	Yes 2 □ No			
Division	or Att	Certification:	4 Homicide determ	mined 28e. Place of building	of Injury - At ho ng, etc. <i>(Specif</i>	ome, farm, str y)	eet, factory, office		28f. Location City or 7	(Street and Numb own, State)	er or Rural Route Number,
_	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certify	ing Physician: To the	best of my kno	wledge, deatl	h occurred at the ti	me, date and	place, and due to t	he cause(s) and ma	anner as stated.
	he Ho in 24 I he Fu pletely	edical	(Check only 2 Medica one)	I Examiner: On the ba and mann		tion and/or in	vestigation, in my	opinion, death	occurred at the tim	e, date and place,	and due to the cause(s)
_	Vithi To the	Ž	29b. Signature and title of certific	er Al	10		29c. Licens	se number		29d. Date signed	(Month, Day, Year)
			· /UYU	Moder	Jun	14.0	100	0576	30	05 - 2	26-2009
			30. Name and address of person 10301 (CEDRO)		e of death (Item	23a) (Type,	All	uradha	Arun M.D	. NO	70907-
	Sta	ite	31. Date filed (Month, Day, Year) 2 . Be	egistrar's Signa	ture		TK J	JACIN WI	M) =	00/00
	Registi	ar	JUN 03	2009 Sent	m B.	par					
				-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 2009

DHMH 17 Rev 1/2001

Registrar DHMH 17 Rev 1/2001

State

Michael B. Price,

31. Date filed (Month: Day, Year)

M.D.

7300 Van Dusen Road, Laurel, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) June 1, 2009 Year Physician Schnittke 9:15 p M Flora /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Kensington Nursing & Rehab. Center Kensington Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours 065-68-5859 1 □ M 2 😾 F 82 June 28, 1926 Ŕussia Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo Maryland Montgomery Kensington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. ō 3000 McComas Avenue 20295 TISA items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. □Yes 2□No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 □Yes 2 No Specify: Specify: White ģ 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Architect Architecture Department of Health and Mental Hygie Important: If item 27 is marked other t any injury or other traumatic event, In once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leo Tsiperovich Esther Rozhasky 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Olga Meerson/Daughter 5616 Greentree Road, Bethesda, MD 20817 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Vladamir Russian
Orthodox Cemetery June 4 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation ≠ 5 ☐ Other (Specify) 2009 Jackson, New Jersey 21. Signature of ungral Service Licens 22 Name and Address of Facility Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 2090] Approximate Interval Between Onset and Death 23a. Part 1. Enter the dise see, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Diabetes Mellitus /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and P.O. Box 68760, Physician/Medical d. Date of delivery Year Month contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 Unknown npleted 24b. Were autopsy findings available prior to completion of cause of death?

Director: Certifica Medical

Cause (Disease or injury that initiated events resulting in death) Last	c		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		23d. Date of deliver
Part II. Other significant conditions Asthma, Dementia	contributing to death but not resulting in the underlying cause given in Part I.		use contribute to the
		24a. Was an autopsy performed?	24b. Were autopoprior to com death?
25. Was case referred to medical	26. Place of Death	(Check only one)	
examiner? 1 ☐ Yes 2 ☑No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4X Nursing Hom	e 5 Residence	6 ☐ Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigati	(Month, Day, Year) Injury Work?	8d. Describe how inju	ury occurred

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Be	25.
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tion:	27.

3 Suicide

6 ☐ Could not be determined 4 Homicide

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

June 2, 2009

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number

29b. Signature and title of certifier

D64624

29d. Date signed (Month, Day, Year)

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sandeep Sharma, MD

743 Summer Walk Drive, Gaithersburg, MD 20878

State Registrar 31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** June 2, 2009 7:15 P M Katherine Sharp Stoll /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert Solomons 11609 Asbury Circle 9. Birthplace (State or Foreign Country) Ohio If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days (Month, Day, Year) 08/07/1918 Hours Min. 1 □ M 2 1 F 90 002-14-6781 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10h County 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, Ing Mcd.cal Examinativitat be muttind at 1 X Yes 2 □ No Director Maryland | Calvert Solomons 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20688 11609 Asbury Circle Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 □ Never Married 2 □ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify. ģ 3℃Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 3 2 should be filed within 7 th and Mental Hygiene.
7 is marked other than "r College (1-4or 5+) Elementary/Secondary (0-12) Education School Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Weimer I. Walter Sharp 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health au
Important; If Item 27 is
any injury or other trau 42015 Gibson Drive Mechanicsville, Maryland 20659 Laurence Stoll / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Wake Forest
Medical School 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3XXRemoval from State 06/04/2009 Winston-Salem, NC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee 22955 Hollywood Road Leonardtown, Maryland 20650 M01206 Kyle S. Simons 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PROGRESSIVE" YEAR, Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 1 □Yes 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 ☐ No 1 □ Yes 2 □ ₩6 26. Place of Death (Check only one) 25. Was case referred to medical director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral din Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. ours after death.

neral Director: A
filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide within 24 hours a 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only and manner stated To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

30. Name and ddress of person who completed cause of leath (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

BUNUL 8

WEIGER

726358

PRINCE FRANKRICK, MD 20678

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 – For State Registrar	State of iv	Ce	ertificate of D		_	giene _{Reg. No.} 2 (009	19676	
ı	Physici	an	Decedent's Name (First, Midd	lle, Last)				2. Date of De Month	Day	Year	3. Time of Death	
4	/Medio		JANE L. SWAN 4a. Facility Name (If not institution	on, give street and number	•)	4b. City, Town, or L	ocation of Death	JUNE 1,		y of Death	1115 P ^M	
ألمريد	Examin	lei	TALBOT HOPSICE		,		LOCALION OF BOART		TALI			
	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. last birthda)	// If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th		ace (State or Foreign	
	Director		220-52-2324 Usual Residence of Decedent	1 □ M 2 XX F	58Yrs.	Worths Days	Tiours Will.	AUG 24,		Oodin	NY	
	hours after death with the Maryland tural", or items 23a or 28a-f show at Examinet must be redified at		10a. State 10b. County	,	10c. City, Town or I	ocation				10	d. Inside City Limits	
	e Mar Ba-f s	Funeral Director	MD TAL	вот	EASTON						1 □Yes ZXXNo	
	ith th	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Count	ry?	
	ath w	<u>ra</u>	9505 GANNON RD			21601			USA			
	items	Ş	11. Marital Status	12. Was Decedent Armed Forces	?	. Was Decedent of His If Yes, specify Cuban	panic Origin? (Sp , Mexican, Puerto	pecify Yes or No Rican, etc.)	- 14. Ra Bla	ice - America ack, White, et		
920	urs aff		1 ☐ Never Married 2 📉 ar 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	(NO	1 ☐ Yes XXNo	Specify:		Speci	fy: WHI	TE	
21215-0036	72 Fra	Completed by	15. Deceder	nt's Education est grade completed)		edent's Usual Occupat		rina	16b. Kind of E	Business/Indi	ustry	
121	within iene.	Idm	Elementary/Secondary (0-12)	College (1-4or	5+) life.	DO NOT use retired)		g				
	e filed wall Hygie other t		17. Father's Name (First, Middle,		OFF	ICE MANAGE	R 18. Mother's Name	- (First Middle	PRINT			
Maryland	betall sed of	Be c	JAMES THOMAS L	ŕ				INA PETO		me)		
<u> </u>	should and Me mark umatic	ျှ	19a. Informant's Name/Relations		19h Mai	ling Address (Street ar				State Zin	Code)	
	nd 2 salth ar 27 is r trau		MICHAEL H. SWA		į.	GANNON RD				i, Otato, Lip	5000)	
ē,	is 1 and of Hei		20a. Method of Disposition		20b. Place of Disp	position (Name of ematory or other place)		Date	20c. Location	- City or Tov	vn, State	
Ē	Pages nent of ant: If its ary or o		1 ☐ Burial 2 🔼 remation 4 ☐ Donation 5 ☐ Other (S			KE CREMATI	i	2009	STEVEN	TTV	k MD	
Baltimore,	permit. Pages Department of Important: If its any Injury or o		21. Signature of Funeral Service		F	22. Name and Address ELLOWS HE	of Facility LFENBEIN	I & NEWN	IAM FUNE	RAL H		
	4D = 60 G		222 Part 1 Enter the disease of		LERONIE	OU S. HARK	TOOM DI.	RASIUN	, MU 21	OUT		
		8 7	23a. Part 1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final	only one cause on each	ine.	nter the mode of dying	, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death	
- 1	Physician /Medical		disease or condition resulting in death) a							9 inds		
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		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):	injelo	nuc		-	-	o mor.	
	cuted or ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	S .								
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9 X	± 5, ∞		IF FEMALE:	O20 Huga autasma				-		'		
on	eath cer attendin for use	sian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	☐ Ectopic pregnancy				ate of deliver	ry Day Year	
P.O. Box	Physician: The law requires that the death cer this certificate has been signed by the attendir al director, page 2 should be detached for use	Physician/N	1 □ Yes 2 ☑ No 9 □ Unknown	9 ☐ Unknown	at time of death 5	Other (specify)						
က် L	s that med b e deta	by P	Part II. Other significant condition	ons contributing to death t	out not resulting in the	underlying cause given	in Part I.	23e. Did tobacco use contribute to the cause of death?				
ğ	quire en sig uld bi	ed b	Hype	Herson				1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknow				
Hecord	e law re has ber e 2 sho	Completed	Ata	ial Fibr	Mation			24a. Was	an 24b.	Were autop	ere autopsy findings available or to completion of cause of	
Ĭ	The page	E O	performed? d							death?	r to completion of cause of th? Yes 2 □ No	
VITAI	siclan: The certificate rector, pag	Be	25. Was case referred to medical examiner?		1377		26. Place of Deat					
	Physical dire		1 ☐ Yes 2 ☐ Mo		ent 2 ER/Outpatie		4 ☐ Nursing Ho	ome 5 Resi	dence 6 🗷 Ot	her (Specify	Hospice.	
DIVISION OF	ling After uner	ioi	27. Manner of Death 1 ☐ Matural 5 ☐ Pendin		ury 28b. Time ay, Year) Injury	Work?		28d. Describe I	now injury occur	rred	,	
<u>s</u>	Attending r death. ector: After by the funer	icat	2 Accident investigned investigation investigat	not be	ium. At home form a		es 2 No	006 1	Di			
2	i Pige	Certification: To	4 ☐ Homicide determ	building, e	jury - At home, farm, s tc. <i>(Specify)</i>	reet, factory, office		City or To		per or Hurai	Route Number,	
7	e Hospital or 124 hours afte e Funeral Dir letely filled in		29a. Certifier 1 ertifyir	ng Physician: To the best Examiner: On the basis	of my knowledge, dea	ath occurred at the time	e, date and place,	and due to the	cause(s) and n	nanner as st	ated.	
1	the hin 2 the	Medical	one)	and manner st	ated.			. ou at the time,				
	5 vit	2	29b. Signature and title of certifie	(2)		29c. License i			29d. Date signe	ed (Month, D	Pay, Year)	
		-	· VVNSU	200		1442	78/		06-1	52-2	2009	
P	.kio		30. Name and address of person	who completed cause of a	death (Item 23a) (Type	Print)	21600	MAA	511	lo-	2009 RASchell	
	Sta	e	31. Date filed (Month, Day Year)	32 Raffiet	rar's Signature	1 .	-1401	VVVY		e) =		
	Registra	ar	JUN ()	3 2009	us d. d	rave						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month)

8-X9

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Son St. Easten, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 🚄 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Sisler E. Thomas /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Allegany Oldtown 18400 Cemetery Road Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year)
Oct 11, 1926 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min Months 1 M 2 F MD 215-38-7581 82 Director Usual Residence of Decedent permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any liqury or other traumatic event, the Medical Eventiner must be negligible. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. Count Oldtown 1 ☐ Yes 2 ☐ No MD Allegany **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21555 18400 Cemetery Road 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2□No Specify: Completed by WWII white 3 XWidowed 4 ☐ Divorced Year or Dates: 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) United States Army Army Intelligence Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Blanche Lillian (Hartsock) Sisler Branson Sisler ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MD 21502 16725 Harves Lane, SE Cumberland Michael Twigg friend 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rocky Gap Veterans Cemetery Date 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 6/15/2009 MD Flintstone 4 □ Donation 5 □ Other (Specify) 21. Signature Fyneral Pervice 22. Name and Address of Facility Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part / Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or beart failure. List only pne cause or each line.

Immediate 0 use (Final disease or or or do non resulting in part)

a.

Tetastata

Due to (or as a consequence of): Approximate Interval Between Onset and Death 2002 **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burlal-tra Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) the 1 □Yes 2 □No detached 9 Unknown à signed to deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I of Vital Records, ð 2 € No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed 1 ☐ Yes 2 ☐ No 1 □Yes 2-1No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA After this of funeral dire Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check on To the 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

of certifier

29b. Signature and title

32. Régistrar's Signature

DA

29c. License number

DR. CUMBERLAND, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Lillian Howze Thomas 05 27 2009 1:40p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/18/1921 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Days Hours 1 M 2X F 87 146-14-1845 NC **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show unt: If other traumatic event, I'm Medical Evan mer must be notified at uny or other traumatic event, I'm Medical Evan mer must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Director Silver Spring Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20903 United States 1307 Dilston Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2**X** If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify Specify: Black <u>چ</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Coilege (1-4or 5+) Elementary/Secondary (0-12) Department of Army Personnel Manager Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk Be Hattie Howze ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6054 Camelback Lane, Columbia, MD Edgar Thomas / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o once. 1 ☐ Buriai 2 X Cremation 3 ☐ Removal from State 5/30/2009 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory Beltsville, MD 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Serv Licensee Taxces 7400 Georgia Avenue, NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction **Physician** Days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed nding physician and use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Pneumonia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2**⊠**No 1 □Yes 1 ☐Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1KI CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Box 68760, P.0. Division of Vital Records, Hospital or Attending

> State Registrar

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

NW

Name and address of person who completed cause of death (Item 23a) (Type, Print)



2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D32332

29d. Date signed (Month, Day, Year)

5/27/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) May 31, Year Physician **2009** 7:30 A TRAHAN ELIE EMTI.E /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville Casey House 8. Date of Birth (Month, Day, Year) 10/17/1937 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months Days Hours Rhode Island 1**X** M 2□ F 71 Director 037 24 1007 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it is Illy like I samile or must be notified at 1 ☐ Yes 2 ☐ No Director 01ney Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with Hygiene. USA 20832 4148 Mt Olney Lane Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1₩ es 2 No If Yes, Give Year or Dates: **Vietnam** 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 9 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic meany injury or other traumatic means. Cancer Research 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edith Cadden Emile Elie Trahan, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4148 Mt Olney Lane Olney, Maryland 20832 Jean Marie Trahan / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ➡Burial 2 ☐ Cremation 3 ☐ Removal from State 6/5/2009 Gate of Heaven Cem. Silver Spring,MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines Rinaldi Funeral Home 21. Signature of Funeral price licens e 11800 New Hampshire Ave Silver Spring, MD 20904 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Lung Cancer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician; The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4x Unknown Hypertension Completed 24b, Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🗆 No 1 ☐ Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? After t 1 Natural 2 Accident 5 Pending investigation 24 hours after death.
 Euneral Director: Afletely filled in by the full 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only and manner stated 29d. Date signed (Month, Day, Year) 29c. License number

2

6001 Muncaster Mill Road Rockville, Maryland Jocelyne T. Kouatchou 32 Registrar's Signatu 31. Date filed (Month, Day, Year)

Kouerchou, mi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

JUN 03

park

D6374

June 1, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene phys. 1 - For Amend 26 per physical Registrar DOR, 6/3/09, LDB Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 2009 9 te//a urner Mai /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Trappe Trappe
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Talbot Old Road Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□ M 2 F Months 90 214 - 32-6200 Usual Residence of Decedent Oct. 8. Maryland Director 10d. Inside City Limits 10b. County 10c. City, Town or Location death with the Marylan 10a. State 28a-f show timer must be notified at 1 ☐ Yes 2 ☐ No Director vappe Talbot 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number or items 23a or 215 21673 6251 rappe Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: Black traumatic event, the Medical Exa-3 Widowed 4 Divorced natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOSPital Dietitian 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jane Askins ပ Emma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is any injury or other trau Hartford Conn. 06112
e 20c. Location - City or Town, State ue Hills Ave. John Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/6/09 Trappe, Mary land Cometery 4 Donation 5 Other (Specify) aradise 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Henry Funeral Home, P.A. 510 washington 3t. Cambridge, MD. 21613 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** atheros disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been so funeral director, page 2 should to Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 K Residence 1□Yes 2♠No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 24 hours after death Funeral Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only within 2 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death Date of Death
 Month 3 Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2009 homas GleN lerry /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Easton 100 Hospita 1emoria If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 442-58-2726 1 M 2 □ F OKlahoMa Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1∩a State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 1 □Yes 2 No **Funeral Director** orchest Hurlock 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U 5 A Crest Road 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 □ Yes 2 🔀 If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Black þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene, Important: If item 27 Is marked other than any injury or other traumatic event, Inc. Ma. once. Elementary/Secondary (0-12) College (1-4or 5+) State College ver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harrison Earlene Thomas ၀ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Crest Road Hurlock, Maryland 21643 Barbara 20c. Location - City of Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Shore Cremation 8/09 Cambridge, MD 61 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
HENRY Funeral 21. Signature of Funeral Service Licenses Home, P. Henry Funeral Home, 310 washington st Cambridge, MD. 21613 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Se (S disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋛ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown is certificate has been s director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After t Natural 5 Pending investigation n 24 hours after death.

e Funeral Director: Aft bletely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis M. DeShields, 219 S. Washington Street, Easton, MD 21601 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

JUN 03 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 300 200 9 0750M Elwood Floyd Tull 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 30/136414 HICOMIO TENIN SULA If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Aug. 25, 1933 7. Age (In yrs. last birthday) Hours Days 1 XM 2 □ F Maryland 75 214-30-9595 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 🗓 No Salisbury Maryland Wicomico 10g. Citizen of What Country? 10e. Street and Number USA 21801 210 Harford Road 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 195 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1954-1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No 1956 Specify. Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Security Company Guard 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Evelyn Rathell Lee Tull 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 210 Harford Road, Salisbury, MD 21801 Helen Foskey Tull/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 6/3/2009 Salisbury, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Parsons Cemetery 22. Name and Address of Facility Zeller Funeral Home, P. O. Box 3171 1212 Old Ocean City Road, Salisbury, 21. Signature of Frineral Service MD 21802 Part 1. Enter the disease, or complications and caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBRUJASCULAR 0445 ACCIDENT Due to (or as a consequence of): ATMENOSCIENUSIS Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Dav Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes

Physician /Medical Examiner

Department of Health a Important: If item 27 Is any Injury or other traconce.

Physician

/Medical

Examiner

Funeral

Director

28a-f shov

Director

Funeral

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Completed

Be

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7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at

72 hours after

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 Is marked other than "

Maryland 21215-0036

altimore,

burial-tran attending physician for use as the burla icate has been signed by the page 2 should be detached certificate funeral director, after death.

I Director: Al n 24 hours after e Funeral Dire

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

IF FEMALE 9 Unknown 25. Was case referred to medical examiner? 1 Yes 2 No

1 🖊 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

Examine Physician/Medical 쥙 Be Completed Certification: To 27. Manner of Death

Medical

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

> 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

5 Pending investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29c. License number 353 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100E CARROCC ST. SALISBURY Med 21801 DESMARAIS JR. mD

State Registrar

completely within 2 To the I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9584 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Year Day **Physician** Sally Ann Tyndall 29 120 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Wicomico Salisbury Rehabilitationa Nursing Ctr 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Dec. 31, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Maryland 1 □ M 2 🔀 F 96 219-03-6040 Dec. 1912 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit, Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Modical Evanning Invate to notified at once. 28a-f show 1 X Yes 2 □ No Director Maryland Wicomico Pittsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 35107 Sunrise Court 21850 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married ປລຸໄປປູ່ໄປດີປ Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo Specify: Specify: White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clothing Manufacturing Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillie Mae Bratten John Campbell 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Massey/Granddaughter 6797 Arvey Road, Parsonsburg, Maryland 21874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 Removal from State Allen Cemetery 6/1/2009 Allen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Zeller Funeral Home, P. O. Box 3171 1212 Old Ocean City Road, Salisbury, 21. Signature of Funeral Service MD 21802 Part1. Enter the disease or complication, hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Let only one control of the cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) oronar condition faz /Medical to (or as a consequence of) Examiner ux Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to or as a consequence of) The law requires that the death certificate be executed ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical signed by the attending I IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been s
completely filled in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No 1 □Yes 2 □No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 📴 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number June 1, 2009 D29349

State

Registrar

lilliam

31. Date filed (Month.

Ave.

Salisbury, MD 21804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

distrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month May 22, 2009 3:45 РМ Rona 1 d David Tippett, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's Hospital Cheverly Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 X M 2 □ F Maryland 213-54-7976 60 26, 1948 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at 1 ☐Yes 2 No Director Maryland | Prince George's Brandywine 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20613 U.S.A. 16306 Baden Naylor Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 🔀 No Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel J. Tippett Catherine Louise Kidwell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Chris Sanders/Sister 11570 Acton Lane, Waldorf, Maryland, 20601 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Trinity Memorial Gdns, 05/29/2009 Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Dicensee 22. Name and Address of Facility 3035 Old Washington Road MØ1190 Huntt Funeral Home Waldorf, Maryland 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Bilateral **Physician** pneumanio Medical Due to (or as a consequence of): Examiner Starhlococcal
Due to (or as a consequence of): Se quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-tran Due to (or as a consequence of): attending physician Physician/Medical the nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for 1 Day in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 TYYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Pailure certificate 1 □Yes 2 ☑ No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28d. Describe how injury occurred WAS
extly days a tree 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 019M 5 Pending investigation 1 Natural February 27, 2009 1 □Yes 2 WNo 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Royte Number, City or Town, State) 16366 Beach Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide home Brandy wine, No

The law requires that the death certificate be executed P.O. Box 68760, Records, Division of Vital

Baltimore, Maryland 21215-0036

e Hospital or Attending Physiclan: '24 hours after death.
9 Funeral Director: After this certifica completely filled in by the To the within 2

State Registrar

Medical

30. Name and address of pers in who completed cause of death (Item 23a) (Type, Print) 11/1AM BOYCE

JUN 0 4 2009

31. Date filed (Month, Day, Year)

29b. Signature and the of certifier

29a. Certifier

(Check only one)

MD 32/Registrar's Signature

and manner stated.

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Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) an manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0043662

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2609 Month **Physician** 4:30 PM 35e homas /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Montgomery Washington Adventist Hospital Takoma Park 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🖫 F Director 578-64-5552 60 n9/23/1948 Virginia Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at tx Yes 2 No Director DC Washington, DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6032 Sligo Mill Rd. NE 20011 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Black \$ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 4yrs Assistant Director/Teacher Private permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Bolden ပ **Evelyn** Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delores Lewis/ Sister 3536 Wilson Ave., Alexandria, VA 22305 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriai 2 ☑ Cremation 3 ☐ Removal from State Riverdale Park Crem. 6/4/2009 Riverdale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Socice Licensee 22. Name and Address of Facility Johnson & Jenkins Funeral Home 20011 716 Kennedy St. NW, Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** oronary /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any heading L. immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician a the burial-Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.O. 9 Unknown 9 X Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No Certification: To 1 🗌 Inpatient 2 11 ER/Outpatient 3 □ DOA this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 📭 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Hospital within 2 To the 1

> State Registrar

Medical

(Check only one)

29b. Signature and title of certifie

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

29c. License number

HOW Carroll

23a) (Type, Print) 30 Name and address of person who completed cause of death (Item

and manner stated

31. Date filed (Month, JUN 0 5 2009 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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more, Maryland 21215-0036	ges 1 an nt of Hea if item ? or other		20a. Method of Disposition 20b. Place of Disposition	(Name of	Date	20c. Location - City	
Ē	Pages nent of ant: If it		4 Donation 5 Other (Specify) Mt Zion	Cem 6	/4/09	Dickers	
Balti	permit. Page Department Important: I any injury o			me and Address of Facility			
	~∪ = « o		23a. Part 1. Enter the disease or complications that caused the death. Do not enter the				e,MD 20850
	Db	77	shock, or heart failure. List only one cause on each line.	, mode of dying, such de o	ardiao or reopriatory t		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) Due to (or as a consequed ce of):	ming Co.	برعر		Jewis-
	Examiner		Sequentially list conditions b.				years
7	sit sed	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	- A /	-1		Dans -
20	te be executed ysician and e burial-transit	xan	that initiated events resulting in death) Last C. Due to (or as a consequence q):		anne		aceje
8760,	The law requires that the death certificate be executed its has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	dical I	d				
Ö	ertifica Jing ph e as th	Med	IF FEMALE:				
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შ.	v requires that the di been signed by the should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the underly	ying cause given in Part I.			te to the cause of death?
ord	require een si nould t		- That failing		1_		Probably 45 Unknown
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<u>a</u>			25. Was case referred to medical	26 Piggs		2 XNo 1 □	Yes 2 No
<u> </u>	Physician: The law this certificate has al director, page 2 a	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3	Other:		idence 6 Other	(Specify)
o u	ding Ph h. After th funeral	D: T	27. Manner of Death 17. Manner of Death 17. Manner of Death 18. Date of Injury (Month, Day, Year) 28. Date of Injury (Month, Day, Year)	28c. Injury at Work?	28d. Describe	how injury occurred	
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Division of Vital Records,	I or At after of Direc	Certification: To	4 Homicide determined 28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	actory, office		wn, State)	nulai noute Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier (Check only (Ch	curred at the time, date and	d place, and due to the	e cause(s) and mann	er as stated.
	the H hin 24 the F(Medical	one) and manner stated.		Josembu at the tille	29d. Date signed (A	
	S O With	2	29b. Signature and title of certifier	29c. License number	41	Haa)	7, 2009
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	V 177	11		
			James to Akras	Prince G	earge los	jula Cl	leverly, MD
	Sta Registr		31. Date filed (Month, Day, Year) JUN 03 2009 32. Registrar's Signature June 9. face	1	J		
	3		JUN UU LUUU KANTA /				

09-04176 Bernard Williams

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

	State of Maryland / Department of H 1- For State Certificate of D		Reg. No. 2009 19689					
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of	of Death 3. Time of Death					
Medical Examiner	Bernard Williams		26, 2009 0020 HIS					
	Tarrier (miles mental miles)	City, Town, or Location of Death	4c. County of Death Prince George's					
Funeral			e of Birth(MM/DD/YYYY) 9. Birthplace (State or					
Funeral Director	226-62-3117 1XM 2F 61 Yrs.	Months Days Hours Min. Feb	o. 26, 1948 Foreign Virginia					
any	Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location		10d. Inside City Limits					
A	DC Washington		1 X Yes 2 No					
the Maryland a or 28a-f show tified at once.		Of. Zip Code	10g. Citizen of What Country?					
the M a or 2 tiffed	4221 East Capitol St., SE Apt.#30	20019	United States					
215-0036 be filed within 72 hours after death with the Maryland mtal Hygiene. ked other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once. Be Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was D	ecedent of Hispanic Origin? (Specify Yes specify Cuban, Mexican, Puerto Rican, et	s or No- 14. Race - American Indian, Black, tc.) White, etc.					
or ite	1 X Yes 2 No 1075	es 2 X No specify:	Specify: Black					
ns afte	or Dates:	Usual Occupation (Give kind of work done						
136 thin 72 hours a te. than "natural edical Examin	Elementary/Secondary (0-12) College (1-4 or 5+)	of working life. DO NOT use retired)						
5-0036 led within 72 hour Hygiene. ther than "natu the Medical Exan Completed	12th Bus D		Metro					
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medice	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, M						
	Arthur Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Av	Raye Smith	ute Number, City or Town, State, Zip Code 20019					
D 21 should and Mer 7 is man	Jean Williams / Wife 4221 Ea	st Capitol St., SE	, Apt.#30, Washington,DC					
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic ev	20a. Method of Disposition 20b. Place of Disposition	n (Name of cemetery, Date	20c. Location - City or Town, State					
nore ages later of it.	Clargand C		09 Washington, DC					
altin mit. P sarime portan iry or	21. Signature of Juneral Service Licensee 22. Nam	ne and Address of Facility McGuir	e Funeral Service, Inc.					
in in page		Georgia Avenue, N						
Physician Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.		atory arrest, shock, or heart Approximate Interval Between Onset and Death					
xaminer	Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardiov	ascular Disease	2343					
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ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):							
Paniner Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							
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50, te be executed ysician and burial - transit	UNPENDED AMENDED							
Box 68760, e death certificate be the attending physic ed for use as the bur hysician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal	death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year					
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Box 6 death cer he attendi d for use a	1 Yes 2 No 9 Unknown g Unknown							
P.O. Be es that the designed by the appearance of detached for the above detached for the above		derlying cause given in Part I. 23	Be. Did tobacco use contribute to the cause of death? Yes 2 ✔ No 3 Probably 4 Unknown					
S, P.(Chronic renal Disease	124	la. Was an 24b. Were autopsy findings available					
cords, law requirements been a 2 should			autopsy prior to completion of cause of performed?					
Division of Vital Records, P.(But or Attending Physician: The law requires that the after death. The Director: After this certificate has been signed led in by the funeral director, page 2 should be deter			✓ Yes 2 No 1 ✓ Yes 2 No					
tal Fician:	25. Was case referred to medical	26.Place of Death (Check only one 3 DOA Other Nursing Home						
FVir Physic er this ral dir	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 V ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of Injury		Describe how injury occurred					
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ISIO Atter r deat ector by the	2 Accident Investigation 28e. Place of Injury - At home, farm, street,		ocation (Street and Number or Rural Route Number, City					
Division o spital or Attending hours after death. neral Director: Aft filled in by the fune Certification:	Suicide 6 Could not be determined (Specify)	or	Town, State)					
		occurred at the time, date and place, and due to the cause(s) and manner as stated. estigation, in my opinion, death occurred at the time, date and place, and due to the cause						
To the Howithin 24 To the Function Completely	29d. Date signed (Month, Day, Year)							
241	29c. License number 29d. Date signed (Month, Day, Y O.C.M.E. May 26, 2009							
	30. Name and address of person who completed cause of death (Item 23a)							
	Laron Locke MD. Assistant Medical Examiner 111 Penn S	Street, Baltimore, MD 21201						
Stat Registra	The state of the s							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 7, 2009 11:00 p.M. White June Orleta Hilyard Izola /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 8. Date of Birth (Month, Day, Year) St. Mary's 25140 Gallant Fox Drive Hollywood If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min Months Hours 1 ☐ M 2 🛣 F Michigan 86 Director 086-16-9174 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10h County 10a State rat", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 XNo Director St. Mary's Hollywood Maryland 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number USA 20636 25140 Gallant Fox Drive permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturat", or items 23a any injury or other traumatic event, If a Modical Examines must once. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2XNo Specify 2 Specify: White 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Thomas Hilyard ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 25140 Gallant Fox Drive, Hollywood, MD 20636 Vickie Frederick/Daughter 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Brinsfield-Echols Cre 06/08/2009 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M01206 22955 Hollywood Rd., Leonardtown, MD 20650 Kyle S. Simons 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Ye ar Day in the past 12 months? 1 □Yes 2 🌁No 5 Other (specify) 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>چ</u> 1 XYes 2 No 3 Probably 4 Unknown has been signed 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No vithin 24 hours after death.

To the Funeral Director: A mpletely filled in by the fu death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P 0 H0055751 30. Name and address person who completed cause of death (Item 23a) (Type, Print) 40900 Merchants Lane, Leonardtown, MD 20650 Jennifer Schmidt, D.0 31. Date filed (Month, Day, Year) JUN 0 8 200 Registrar

			State of Maryland / Dep	partment of Health and ertificate of Death		2004 14641		
			Registrar 1. Decedent's Name (First, Middle, Last)	er timeate or beatir	2. Date of Death	3. Time of Death		
	Physicia	ın	_		Month	Day Year		
	/Medic		John T. Wright, II 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of De	June	9, 2009 9:56 p [™] 4c. County of Death		
	Examin	er	35616 Golf Course Drive	Mechanicsvil		St. Mary's		
	Francis		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 H	rs. 8. Date of Birth			
	Funeral Director		173-56-5821 1⊠M 2□F 47 Yrs.	Months Days Hours Mi	n. (Month, Day, You	Pennsylvania		
			Usual Residence of Decedent					
	ylan		10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits		
	a-f s	cto	Maryland St. Mary's Mecha	nicsville		1 □Yes 2 X No		
	or 28	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?		
	23a 23a ust b		35616 Golf Course Drive	20659		USA		
	filed within 72 hours after death with the Maryland Hygene. ther than "natural", or items 23a or 28a-f show ent, the Medical Extrainer must be notified at	Funeral	Armed Forces?	 Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu- 	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.		
36	s afte	by F	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give	1 ☐ Yes 2 ☑ No Specify:		Specify: Ubit o		
21215-0036	hour:	d b	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	cedent's Usual Occupation	16	b. Kind of Business/Industry		
꺗	"nat	Completed	(Specify only highest grade completed) (Gi	ve kind of work done during most of w . DO NOT use retired)		b. Nind of Edomesor industry		
12	withii ene. than	Ę,	Elementary/Secondary (0-12) College (1-4or 5+)	l & Beverage Dire	ctor	Catering		
9	filed Hygi other		17. Father's Name (First, Middle, Last)		ame (First, Middle, Ma			
Maryland	d be ental ked c	To Be	John T. Wright, I	Mar	y L.	Hoke		
$\overline{\geq}$	shoul nd M mari	F	19a. Informant's Name/Relationship (Type. Print) 19b. Ma	iling Address (Street and Number or	Rural Route Number, C	City or Town, State, Zip Code)		
Š	ulth a 27 is 27 is r trau		Jocelyn Wright/Wife 35	616 Golf Course D	r., Mechani	icsville, MD 20659		
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentle Hylgene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified an once.			position (Name of ematory or other place)		c. Location - City or Town, State		
e E	Page: ent o nt: If		11 I Burial 2 LACremation 3 I Bernoval from State		/10/2009	Charlotte Hall, MD		
≣	nit. F Partm ortar Injur		21. Signature of Funeral Service Licensee					
ä	Per Per any any		Kyle Simons M01206	30195 Three Note	h Rd., Chai	Home, P.A. Clotte Hall, MD 20622		
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8760	ficate be executed physician and s the burial-transit	dical	d					
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Ö	e law r has b ye 2 sh	ple			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of		
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בַ	ing P	on:	27. Manner of Death 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day, Year) 28b. Time Injury	y Work?	28d. Describe how	injury occurred		
<u>sio</u>	tend leath tor: / the f	cati	2 Accident investigation 3 Suicide 6 Could not be 28e Place of Injury . At home farm	M 1 Yes 2 No	20f Location (Ctra	et and Number or Rural Route Number,		
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	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending in the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 12 Certifying Physician: To the best of my knowledge, do	eath occurred at the time, date and n	ace, and due to the car	use(s) and manner as stated.		
	Hos 24 hc Fun etely	lica	(Check only one) 2 Medical Examiner: On the basis of examination and/o and manner stated.	r investigation, in my opinion, death o	ccurred at the time, dat	e and place, and due to the cause(s)		
	o the	Medical	29b. Signature and title of certifier	29c. License number	296	d. Date signed (Month, Day, Year)		
				HMSKO	5/	(0/18/19		
	W.		30. Name and address of person who completed cause of death (Item 23a) (Tyr	ne Print)	3 [0/10/0/		
	120			Merchants Lane, I	eonardtown	. MD 20650		
	Sta	te	31. Date filed (Month, Day, Year) 32. Legistrar's Signature	A. A.	.conaracown	,		
	Registr		JUN 11 2009 Anna B.	para				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 9 1 - State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2220 5 25 09 Frances Wootten 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) HICOMICO REGIONAL 50/156414 TENINSULA If Under 1 Year | If Under 24 H 8. Date of Birth (Month, Day, Year) July 12,1927 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Days Months 1 □ M 2 🛛 F Maryland 81 218-20-6249 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Maryland | Wicomico Salisbury 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21804 USA 200 Civic Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married White 1 □Yes 2 No Specify. 3 ☐ Widowed 4 🕅 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Company Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maude Mae Majors 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5565 Ben Davis Road, Pittsville, Maryland 21850 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 6/3/2009 Crematory of Delmarva Delmar, Delaware Zeller Funeral Home, P. O. Box 3171 1212 Old Ocean City Road, Salisbury, Approximate Interval Between Onset and Death Complications of R hip Due to (or as a consequence of): full Due to (or as a consequence of) Due to (or as a consequence of):

Physician /Medical Examiner

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau once.

Physician

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show

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72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

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Exami physician and s the burial-trans Physician/Medical attending properties of the second as been signed by the 2 should be detached \$ Completed funeral director, Be this After t

Hospital or Attending P 4 hours after death.
Funeral Director: After t ely filled in by the funera within 24 hours a

requires that the death certificate be executed

Box 68760,

P.0.

Division of Vital Records,

Certification: To

State

John Irvin Wilkins 19a. Informant's Name/Relationship (Type. Print) David J. Morris, Jr./Son 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ature of Juneral Service endue 23a. Part 1. Enter the disease, or con plications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. mediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Dementra 24b. Were autopsy findings available prior to completion of cause of death? 45W 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) \$/24|09 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation ground level 1100 am 1 ☐ Yes 2 X No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide Salisbury 200 Civic Hue, hone Nursina 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number

DHMH 17 Rev 1/2001

Registrar

R.M.C.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Snyder, m.D

145049

Carroll St. Salisbury, mD

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 2009 Year **Physician** FLORENCE ORVELLA June 2:45 A M KUKRAL WESP /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Brooke Grove Rehab and Nursing Sandy Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 508-16-0136 88 Director April 8 1921 Nebraska Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f shov edical Examiner must be notified at 28a-f show 1 ☐ Yes 2 X No Md. Montgomery Olney Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with Hygiene. 3504 King William Drive 20832 United States Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married White 1 ☐ Yes 2 🗷 No Baltimore, Maryland 21215-0036 Specify Specify 2 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry traumatic event, the Medical d 2 should be filed within 3 th and Mental Hygiene. **7 Is marked other than "** Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant U. S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Joseph Kukral Eva Josephine Oberle ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is n any injury or other traun William H. Wesp, III / Son 1 Lake Louise Dr., #13, Bellingham, Washington 98229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/4/09 Metropolitan Crem. Alexandria, Virginia 21. Signatu / i Funera Service / censee 22. Name and Address of Facility
Muriel H. Barber Funeral Home 00970 P. O. Box 5038, Laytonsville, Md. 20882 23a. Parv. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shipck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 5 Years Chronic Obstructive Lung Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed burial-transit Due to (or as a consequence of) P.O. Box 68760, ed by the attending physician detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown been signed be should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 Coronary Artery Disease 1 Yes 2 No 3 Probably 4 Unknown iis certificate has been si director, page 2 should ! Completed 24b. Were autopsy findings available prior to completion of cause of death? Atrial Fibrillation 24a. Was an autopsy perform rmed? 2 ☑ No 1 ☐ Yes 2 ☐ No 1∏ Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 18726 June 3, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 20832 18111 Prince Philip Dr., T-10, Olney, Md. Arthur Schoengold, M.D. 31. Date filed (Month, Day, Year) . Registrar's Signature State parks

DHMH 17 Rev 1/2001

Registrar

JUN 03 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. State
Registrar6_10_09Amend#20b.20c.PerFHPQCcr Certificate of Death Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:45 A.M Corine Wright Wheeler June 02, 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Months Days 1 □ M 2 🔀 F Collington, Md. 82 09/14/1926 213-24-3937 **Director** Usual Residence of Decedent 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, I're Medical Exprimer mast be notified at 1 Yes 2 No Bowie Prince George's Director Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20729 U.S.A. 6705 High Bridge Road Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 1 Never Married 2 Married African-Baltimore, Maryland 21215-0036 1 □Yes 2K□No Specify: Specify: þ 3X Widowed 4 ☐ Divorced American Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) s 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other than Own Home Homemaker 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Johnson Allen Wright 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2210 Wintergreen Ave., District Hgts., Md. 20747 Phillip Gary Wheeler/Son 20b. Place of Disposition (Name of Fort Lincoln Cemerals).

Harmony Mem. Park 20c. Location - City or Town, State Date 20a. Method of Disposition Pages 1 Brentwood permit. Pages Department of Important: If it any injury or or rtment of 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Landover, Maryland 06/09/09 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility gron & Sons Co., Inc. 21. Signature of Funeral Service Licensee auc 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760 attending physiciar Physician/Medical the as IF FEMALE: nse 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day for (5 ☐ Other (specify) P.0. the detached 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown ficate has been si r, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 221No 2 No 1 ☐ Yes 1 □ Yes 25. Was case referred to medical examiner?
1 ★ Yes 2 ☐ No 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural Date of Injury (Month, Day, Year) 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No death. nours after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ö To the Hospital within 24 hours a To the Funeral Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ca (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

31. Date filed (Month, Day, Year)

KENNEDX 32. Registrar's Signature

2003

MD

30. Name and address of person who completed cause of death (Item 26) (Type, Print)

MEDICAL PARKWAY, ANNAPOLIS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-04545 State of Maryland / Department of Health and Mental Hygiene 2009 Joseph Wright 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ 0631 hrs June 8, 2009 Wright Joe Lynn Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Capitol Heights 1208 Capitol Heights Boulevard If Under 1 Year | If Under 24Hrs. | 8. Date of Birth(MM/DD/YYYY) | 9. Birthplace (State of 7. Age (In yrs. last birthday) 5. Social Security Number oreignWashington, Funeral Months Days Hours August 24,1956 Country) D.C. Director 52 1 X M 2 579-76-0153 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 X Yes 2 No 23a or 28a-f show notified at once, Prince Georges Capitol Heights Maryland death with the Maryfand Director 10f, Zip Code 10g, Citizen of What Country? 10e. Street and Number 1208 Capitol Heights Boulevard 20743 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. Armed Forces? Never Married 2 X Married 2 X No Yes **Black** Specify: Yes 2 X No specify: Pages 1 and 2 should be filed within 72 hours after tent of Health and Mental Hygiene. If Yes, Give Year Widowed Divorced \$ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Medical Construction 21215-0036 Carpenter 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) to a Taliaferro marked Sarah Esther Joseph Louis Be Wright 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **t** (**w1fe**) 19a Informant's Name/Relationship (Type, Print)
Towanna Antornettee Jones Wright 6919 Quincy Street: Landover, Maryland 20785 Sarah E. Brown (Mother) . He. If item 2, - trau Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, June 15, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 2009 permit. Pagi Department Resurrection Cemetery Ower Specify Denation 5 21. Signature of Funer & that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Enter the disease, or complications **Physician** failure. List only one cause on each line /Medical Heroin and alcohol intoxication Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit executed $X_{AMENDED} #1$ as noted, 23a,27,28a-f,perME, g892 6/24/09 TT Physician/Medical XUNPENDED ling physician a as the burial -68760 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Day Month by the attending packed for use as the 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Live birth 2 past 12 months? Pregnant at time of death Other (Specify) 5 Box 1 Yes 2 No 9 Unknown g Unknown contributing to death but not resulting in the underlying cause given in Part I. signed by the Part II. Other significant conditions o \$ σ. Completed Records, 24a. Was an peen autopsy has death? performed? ✓ Yes 2 1 V Yes certificate 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Be Other₄ Hospital: examiner? Nursing Home 5 Residence 6 V Other: Scene DOA Inpatient 2 ER/Outpatient 3 this 1 🗸 Yes ۵ 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 1 Yes 2 X No Natural Pending Director: Fd 6/8/09 Fd 6:25 am Accident 2 Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be 3 Suicide found at home determined

20c. Location - City or Town, State Clinton, Maryland 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 Approximate Interval Between Onset and Death Hospital or Attending Physician: The law requires that the death certificate be Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✔ Unknown 24b. Were autopsy findings available prior to completion of cause of No Division 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1208 Capitol Heights Blvd Capitol Heights, MD Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the 1 one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier June 9, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Donna M. Vincenti, MD JUN 1 5 2009 State Registra DHMH 17 Rev 1/2001 **ORIGINAL** OCME

2009 19696 State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Dawn Stephanie Williams 1- For State

		Registrar		Certifica	ile oi	Deam					eg. No.		
Physicia	an/	Decedent's Name (First, Middle,Last) Decedent's Name (First, Middle,Last)									ath Day	Year	3. Time of Death
edical Exami	ner	Dawn Stephanie	Williams							June 7, 2			1056 hrs
		4a. Facility Name (if not institution, g	ive street and number)		4	b. City, Tov	vn, or Lo	cation of	Death		4c. Co	ounty of Dea	ath
		1339 Pentwood Road				Baltimo	ге				1	n/a	
Funeral		Social Security Number 6.	Sex 7. Age (Ir	n yrs. last birth	nday)	If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYY					/YYYY) 9. E	Birthplace (State or	
Director			,	•		Months	Days	Hours	Min.			Fore	eign
Director		220-84-3095	M 2X F	47	Yrs.					05/30	/1962		Country) MD
		Usual Residence of Decedent											Table
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Maryland 28a-f show 1 at once.	윙	10e. Street and Number				10f. Zip C	ode		_		10g. Citizen	of What Co	ountry?
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h wi	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.		s Decedent es, specify (ify Yes or N can. etc.)	0- 14.	White, etc.	erican Indian, Black,
deat or ite	ᆵ	1 Never Married 2 Marrie	1 Yes 2 X	No						. ,			,
after	by	3 Widowed 4 X Divorce	ed If Yes, Give Year or Dates:	Yes 2			Sp	ecify:Bla	ck				
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in Hy	Be C	·	,					Domoi	tha T	741146	ma		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		Donald Chambers 19a. Informant's Name/Relationship	(Type Print)	19h	Mailing	Address	(Street :	and Numb	LIId V	Willia al Route No	mber City	or Town, Sta	ate, Zip Code)
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e, MD 21215-0036 I and 2 should be filted within 72 hours after death with the Maryland Health and Mental Hygiene item 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once		Floyd Simmons/ S	Son							imore,			or Town, State
r tr		20a. Method of Disposition 1 X Burial 2 Cremation	3 Demoval from State		ory or oth	ner place)		· 1				•	
Baltimore, permit. Pages 1 an Department of Her Important: If ite		4 Donation 5 Other Speci		Loude	n P	ark	Cem		6-1	6-09	Bal	∟timo	re, MD
nit. I		21. Sign ture of Funeral Service Lic			1 22. N	lame and A	ddress_c	of Facility	_				
Baltimore, ME permit. Pages 1 and 2 s Department of Health as Important: If item 27 injury or other traum	- 4	N. A.			Ro	nald :	ľayl	or I	I Fu	neral	Home		
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Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death											
raminer			a. Hypertensi		neros	scler	otic	car	diov	ascula	ar dis	sease	Death
,		or condition resulting in death)	Due to (or as a consequ	ence of):									
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	aminer	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequ	ence of):									
	Ë	(Disease or injury that initiated	c. Due to (or as a consequ	ence of):									
cuted ind transit	Ë	events resulting in death) Last		01100 01).									_ i l
xecul and rand	a		d. 23a	,27,per	mE.	g892	6/2	4/09	TT				
Division of Vital Records, P.O. Box 68760, Hospial or Attaching Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and lely filled in by the funeral director, page 2 should be detached for use as the burial trans	an/Medical	X UNPENDED	AMENDED ZJa	, _ , , [,	8							
68760, ertificate be ding physici e as the buri	/M	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome	of pregnancy	[]			7				Date of deliv	
68 ertifi	ian	past 12 months?	1 Live birth	2 of dooth	-	tal death		!Ectopic	pregnand	СУ	M	lonth	Day Year
Box e death c the atten ed for us	sic	1 Yes 2 No 9 🗸 Unkno	wn a Pregnant at tim	ie or death 5	Otl	her (Specif	(y)				1		
Box 6 ne death cer the attendi	Physicia		9 Olikilowii							T00- Did	122222112	a contribute	to the cause of death?
O. hat th	by F	Part II. Other significant condition	is contributing to death bi	ut not resulting	g in the u	inderlying o	ause giv	ven in Par	τι.				
ires that signed										1 Y	es 2 l	No 3 P	Probably 4 🗸 Unknown
of Vital Records, ng Physician: The law requir ther this certificate has been s neral director, page 2 should	ompleted									24a. Wa			autopsy findings available to completion of cause of
COI law has 2.2.st	du									per	opsy formed?	death	1?
Re The icate	Ç									1 Yes	2 No	1 🗸	Yes 2 No
tal Re ian: The certificate ector, page	Be (25. Was case referred to medical examiner?				2€		of Death (Check on	ly one)			
Vit his c	0	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient	2 ER/O	utpatient	3 DC	A C	Other 4	Nursing	Home 5	Residenc	ce 6 🗸 Ot	ther: Scene
ing Ph After t	<u>-</u>	27. Manner of Death	28a. Date of Injury (Month, Day,Year	28b.	Time of I	njury 28	lc. Injury	at Work?	? 2	8d. Describ	e how injury	occurred /	
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Division Hospital or Attendin 24 hours after death. Funeral Director:	Certification:	3 Suicide 6 Could n	ot be	y · Actionic, ic	iiii, ba c	ot, 100tory, t	J.1100 De	mamg, oto		or Town			
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e Ho	29a. Certifier (Check only one) 29m Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									stated.			
Di To the Hospital within 24 hours a To the Funeral I completely filled	and manner stated.									o the cause(s)			
F×Fö	Me	29b. Signature and title of certifier	1/1			29c.	License	number			29d. Da	ate signed ((Month, Day, Year)
	O.C.M.E. June 8, 20								8, 2009				
		our rea	ney III	th (lte 00-)									
OCME		 Nam and address of person who Melissa Brassell, MD 	no completed cause of dea Assistant Medical E		111 🗆	Penn Str	oot Ra	altimore	MD2	1201			
						SIIII SUE	oci, Da	and in the	, IVID Z	1201			
St	tate	31. Date filed (Month, Day 2009 ^{ar)}	32. Registrar's	Sign Jure									
Regis		HIM I WAIMIN											

DHMH 17 Rev 1/2001

			1- State Registrar	ns State of Maryla 26,28a-f pe	nd/Dep r me 88	artment of I	lealth and M	lental Hyg	jiene 009	19697
			1. Decedent's Name (First, Middle, L	ast)	· · · · · · · · · · · · · · · · · · ·			2. Date of Dear Month	th Day Year	3. Time of Death
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	Examin		4a. Facility Name (If not institution, g				or Location of Death		4c. County of Dea	+
			19242 Garre	H Highwa	4	OAK	CAND		Garre	eN
Ī	Funeral	1			s. last birthday, Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	9. Bi	rthplace (State or Foreign ountry) MD
	Director		Usual Residence of Decedent	11				our i,	1001	IVID
	within 72 hours after death with the Maryland ene. than 'natural', or Items 23e or 28e-1 show he Medical Exaire as must be codified at	_	10a. State 10b. County MD Alleg		City, Town or L	tburg				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	he Ma	ecto	10e. Street and Number			10f. Zip Code		1	10g. Citizen of What C	
	with with Ba or 3	by Funeral Director	81 Washington S	Street		Toi. Zip code	21532		USA	
	ms 2;	era	11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Decedent of I	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Am	
(0	r Iter	Fur	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1		1 ☐ Yes 2 ☐ No		Hican, etc.)		ite, etc.
03	al', o	by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates: Kol	rea	TLI Yes 2LINO	Specify:		Specify: W	hite
2-0	72 hc natul	eted	15. Decedent's (Specify only highest of		16a. Dece	dent's Usual Occup	pation during most of work ed)	ing	16b. Kind of Business	s/Industry
21215-0036	ithin	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)					Health Dor	artmont
	filed withi Hygiene. other thar ant, the M	ပ္ပ	<u> </u>		FUM	onmental	Sanitarian	a (Eint Middle	Health Dep	Dartment
and	ould be fil Mental H arked ott	To Be	17. Father's Name (First, Middle, La Dr. Charles C.				Emma		ck) Zimmer	mann
Maryland	2 sh and and is m	-	19a. Informant's Name/Relationship Mariella Zimmeri	n (Type, Print) mann wife	19b. Mail 81 \	ing Address <i>(Str</i> ee) Vashington	and Number or Rur Street	al Route Number Frost	r, City or Town, State, burg	Zip Code) MD 21532
	tem 27 tem 27 other tr		20a, Method of Disposition	1	. Place of Disp	osition (Name of ematory or other pla		Date	20c. Location - City o	r Town, State
Baltimore	Pages nent of I unt: If it		1 ☐Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spe		ocky Gap	Veterans (Cemetery	6/12/2009	Flintstone	e MD
Ħ	permit. Pag Department Important: I any injury o		21. Signature Funer I Service Lice		2	2. Name-and Addre	en Fineral H	ome PA		
m	permit. Departr Imports any inj		1/1/1/	1///		•			rland. MD 215	502
	/Medical Examiner	Examiner	23a. Part1. Enter the disease or of shook, or heart failure. List of Immediate Cause (Final disease or condition resulting in depth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cons	equence of):	1	9749_			Interval Between Onset and Death Commonwealth
.O. Box 68760,	he death certificate be executed the attending physician and shed for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	gnancy etal death 3	□Ectopic pregnanc	зу		23d. Date of d Month	elivery Day Year
Ф	uires that the de signed by the a d be detached f	by Ph	Part II. Other significant condition	s contributing to death but not	resulting in the	underlying cause g	iven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
rds	quires nn sigr uld be	q pa		_ ,				1 🗆 Y	/es 2 □ No 3 □ I	Probably 4 Onknown
Records,	The law requires that the ate has been signed by th page 2 should be detache	Completed							rmed? prior to	autopsy findings available o completion of cause of ? es 2 \(\text{No}\)
Vital	Physician: this certificanal director, is	Bec	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only o	ne)	
of V	nysic als ce	2	1 Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatie	int 3□ DOA Of	ther: 4 - Nursing H			pecify)At Scene
0 0	ng PI Iter th	ü.	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury Found Day Year	28b. Time Injury	We			now injury occurred	
Ö	Attending ir death. ector: After by the fune	atle	2 Accident investiga	06/08/2009	Unknov	VII]Yes 2 X ∏No		t hanged	
Division	or Atta	Certification;	3. Suicide 6 □ Could no 4 □ Homicide determin		t home, farm, s ecify)	treet, factory, office			Street and Number or vn, State 19242 (Oakland,	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ical C	(Check only 2 Medical Ex	Physician: To the best of my caminer: On the basis of exam	knowledge, dea ination and/or i	th occurred at the to	time, date and place	and due to the	cause(s) and manner	as stated.
	thin 2 thin 2 the mplet	Medicai	29b. Signature and title of certifier	and manner stated.		29c. Licer	nse number '		29d. Date ≸igned (Mo	nth, Day, Year)
	F 3 F 8		D. 10) (a H	16100		6/9/	19
			30. Name and address of person w	no completed cause of death (tem 23a) (Type	Print)	ح د ا ه		24 110	1
			So. I wate and address of person wi	N. J. W. J. W. J. W. W. W. W. W. W. W. W. W. W. W. W. W.	DA L	91111	L.A. no	and	akland	2 WU
	Sta	ite.	31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature	IOWIL	YICIE	2 W V O		71550
	Regist			32009 Burn	1.	barker				

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10f &18 Per FH C893 7706 609 TH C893 17706 Health and Mental Hygiene For State Registral Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician Albert** June 9. Lillian Gordon 2009 10:16P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rebecca House Potomac, Maryland Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yea 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 F Months Days Hours 469 46 6161 97 April 8,1912 Director Minnesota Usual Residence of Decedent death with the Maryland 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examiner Innet be recilied at once. 1 ☐ Yes 2 No Directo Maryland Montgomery Potomac Village 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 20854 9910 River Road 20850 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TXNo Specify Specify: White þ 3 ★Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social Worker Public School System 17. Father's Name (First, Middle, Last) 18 Morber's Name (First Middle Maiden Symame) Be Gordon Abraham Resuick Unknown မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Merry Lymn / Daughter 9608 Barkston Court Rockville, Maryland 20850 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State United Hebrew Cem. 6/12/2009 Minneapolis, Minnesota 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Hines Rinaldi Funeral Home 21. Signature of Funeral Service Line ns 11800 New Hampshire Ave Silver Spring, MD 20904 23a. art1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Cerebral Vascular Accident /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last burial-tra Due to (or as a consequence of) physician sthe burial-Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 No 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify Home) 1∐Yes 2⊒No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending of thours after death.

Funeral Director: Af letely filled in by the fur investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D35791 June 10, 2009 30. Name and address of person who completed cause of death (Item 239) Merlyn Vemery, M.D. 9801 Georgia Avenue Silver Spring, Maryland 20902

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State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 11:00 AM June 18, 2009 Giovanni Arrighi /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3912 Cloverhill Rd. Baltimore Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs._ Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min. Months Days Hours 1. M 2□ F 71 07/07/1937 Italy 051-62-5524 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examinar must be notified at 1XYes 2 No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 Per.Resident 3912 Cloverhill Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "natural", or ite 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation. 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) John Hopkins Elementary/Secondary (0-12) College (1-4or 5+) University Professor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Renato Arrighi Luciana Jucker မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traun once. Beverly Silver/Wife 3912 Cloverhill Rd. Baltimore, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Jun 1 ☐ Burial 2. Cremation 3 ☐ Removal from State 2009 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licensee NO144 Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy cate has been signed by the atte page 2 should be detached for i Year 5 ☐ Other (specify) 2 🖳 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗹 No 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🔲 Homicide To the Hospital within 24 hours a To the Funeral L 29a. Certifie 1 🗂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier June 19, 2009 . Charles St. Balto Md. 2120% who completed cause of death (Hem 23a) (Type, Print) 30. Name and address of person BMC 6761 31. Date filed (Month, Day 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Nomy P. Blancaflor /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number Examiner 8. Date of Birth (Month, Day, Year September Sex Y□ M 2□ F 5. Social Security Number 7. Age (In yrs. last b **Funeral** Year) Days Hours Months 20,1925 Phillipines 83 331-40-0375 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County Department of Health and Mental Hygiene innortant, or items 23a or 28a-f show Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination and once. **Funeral Director** Rosedale Md. Balto. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 21237 6709 Havenoak Road B1 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Blancaflor Nom 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify Specify: Filipino Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Education Professor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be è Isabelo Blancaflor Fredesvinda Panlasigui 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6709 Havenoak Road Bl Rosedale, Md. Elena Blancaflor Spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6-20-2009 Baltimore City, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature of Fundal Service 22. Name and Address of Facility Nottingham, Md. 21236 9705 Belair Road

Physician /Medical Examiner

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

disease or condition resulting in death)

23a. Part 1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final

omplications that caused the death. Do not enter the mode of dying, such as cardiac or really one cause on each line.	Interval Between
a. Due to (or as a consequence if):	
b	
c	
d	
23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy	23d. Date of delivery Month Day Ye

Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit

certificate has been signed by the rector, page 2 should be detached

funeral director,

After this

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

the

Completed by

æ

Medical Certification: To

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 Unknown

4 Pregnant at time of death

5 Other (specify) 9 Unknown

23e. Did tobacco use contribute to the cause of death?

3 Probably 4 ☑ Unknown

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐ Yes 2√ No

25PM

Year

200

USA

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performe 1 ☐Yes 2 No

25. Was case referred to medical 1 Yes 2 No

Date of Injury (Month, Day, Year) 28b. Time of Injury

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

1 🗌 Yes

27. Manner of Death 1 Natural 2 Accident 3 Suicide

4 Homicide

5 Pending investigation 6 Could not be determined

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 🗌 No

29a. Certifier (Check only

1 🔼 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

Charles 31. Date filed (Month, Day,

5601 Loch 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Physician 2:15 am^M June 19, 2009 Thomas Albert Burns /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death <u>1525 Williams Avenue</u> Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 9/9/1920 Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) Funeral **№** M 2□ F Months Days Hours Director 88 Pennsylvania 207-07-2731 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov other traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 Yes 2 No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 1525 Williams Avenue 21221 S. A. 12. Was Decedent Ever in U.S. Armed Forces?

TXXYes 2 No 1946; Give Year or Dates: 194 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1943 Baltimore, Maryland 21215-0036 ò 1 □Yes 2 XNo Completed by Specify: 3 Widowed 4 ☐ Divorced 1945 White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene.

Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Steel Mill Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Anthony Burns Pekarik Anna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 siment of Health ar f Health tem 27 Joyce Dermyer (Daughter) Department of Heal Important: If item 2 any Injury or other once. 75 Open Gate Court Perry Hall, Maryland 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 XBurial 2 Cremation 3 Removal from State 6/22 2009 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gard. Middle River, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 23a. Part 1. Enter the disease, or a plic size that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Percbrol YASEULAY ACCIDENT Physician /Medical Examiner ENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 2 No P.0. 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24a. Was an autopsy performed? 1 □Yes 2 🛣 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 XNo Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) License number 30. Name and address of

Registrar
DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#30perDVR,G892.6/19/09,WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 10:35 P^M 2009 Mary Louise Butler /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 1700 N. Gay Street Baltimore eriyear | If Under 24 Hrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 5. Social Security Number **Funeral** Min Months Days Hours 1 □ M 2 🗓 F 75 Yrs 219-28-2873 10-18-1933 Va Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar: ust be mutified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State X Yes 2 No Director N/A Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21213 1700 N. Gay Street U S Α Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑ No Specify Specify: ģ 3 Widowed 4 Divorced **Black** Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+ N/A 10th grade Disabled Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Queen E. Harris Robert Freeman ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Balto, MD 21213 3325 Ravenwood Avenue Zina Brown -Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Pk 6-18-2009 Randallstown, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March East F/H Jame 1101 E. North Avenue Balto, MD 21202 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 10 COValle /Medical Due to (or a consequence of). 3month Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 un crean attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐Yes 2 ☐ No 1 ☐Yes 2 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 25(No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 2 Accident 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No n 24 hours after death. le Funeral Director: A bletely filled in by the fu 6 □ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

JUN 1 9 2009

32. Registrar's Signature

Karen M. Donaldson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 1128 PM Melissa Beni 06 15 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** of Maryland Med Center University Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 □ M 2 🗓 F 214-88-9815 8-29-1971 37 MD Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Michael Expirition of the restitute and the once. 1 Yes 2 No Director MD N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 753 Exeter Hall 21218 U S Α Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: M Never Married 2 Married 1 ☐Yes 2X No Specify. Black Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 12th grade N/A17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Charles Benjamin ပ Allie Mouzon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Allie Benjamin-Mother Darlington, S.C. 29532 rate 20c. Location - City or Town, State 108 Davis Street 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Greenmount 6-19-2009 Balto, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March East F/H 21202 Warna 1101 E. North Avenue Avenue Balto, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumor /Medical Due to (or as a consequence of): Neeks **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown HIV Completed Be Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,ರ್ನ

the Maryland

Baltimore, Maryland 21215-0036

burial-trar after death. within 24 hours a

Hepatitis C				24a. Was an autopsy performed? 1 □ Yes 2 □ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No								
5. Was case referred to medical		26. Place of Death (Check only one)											
examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2] ER/Outpatient 3 ☐ DC	Home 5 ☐ Residence 6	e 5 ☐ Residence 6 ☐ Other (Specify)									
7. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	8c. Injury at Work? 1 ∐Yes 2 ∐No	28d. Describe how injury	occurred								
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine		ome, farm, street, factory	28f. Location (Street and City or Town, State)	8f. Location (Street and Number or Rural Route Number, City or Town, State)									
	Physician: To the best of my kno aminer: On the basis of examina												

29b. Signature and title of certifier

29c. License number 619135159 29d. Date signed (Month, Day, Year) 6/16/09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Katie Book, M.D. 22 South

Greene St. Baltimore, MD

State Registrar

Medical

and manner stated.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 6:35 AM 2009 Julyeth 19, Mary Elliott Buzby **Physician** /Medical 4c. County of Death Baltimore 4a...Facility Name (If pot institution, give street and number) 4b. City, Town, or Location of Death Examiner Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth 1 2 Par. 3 22 7. Age (Pryrs. last birthday) 6. Sex 5. Social Security Number 212-12-2291 **Funeral** MD 1□M 2KF Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic event, the Madical Exam for must be notified at once. 1 ☐ Yes 2 No Towson MD Baltimore **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 21204 10e. Street and Number USA 615 Chestnut Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 20 No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify White Specify: Baltimore, Maryland 21215-0036 Be Completed by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry Own Home 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Minnie Pauline Stevens George Brewer Mayo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S 6911 Bellona Ave. Baltimore, MD 21212 19a. Informant's Name/Relationship (Type, Print) Carole Goebel/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory Jah 20 20a. Method of Disposition Beltsville, Maryland 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 2009 21. Signature of Funeral Service Licensee Caramana Andress of Fruiteral Alternatives MO1443 8717 Green Pastures Drive Baltimore, Maryland Kette 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) mon 1 **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and thed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 2 1 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice 26. Place of peath Check onlone 25. Was case referred to medical examiner? Be Other: Oursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No funeral dir 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification; 5 Pending investigation 1 Hatural 2 🗆 No 1 🗌 Yes 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Perifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier June 19,2009 · mo 6761 N. Chules St. Batto, Md 21200 d cause of death (Item 23a) (Type, Print). 32. Registrar's Signature 31. Date # State Registrar

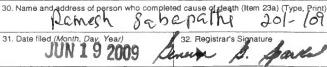
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. Ne. UU9 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 15 Day 2009 **Physician** 12.40 AM Barnheast JUNE Frank /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Ellicott City Health & Rehab Ellicott City Howard If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 1 M 2 ☐ F Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** MD MD 212-48-3672 62 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itama 23a or 28e-f show It e Madical Examinat a ust be notified at MD 1 Yes 2 No Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3725 Mt. Pleasant Ave. 21224 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Amed Forces? 1. 2 Yes 2 □ No If Yes, Give Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White à If Yes, Give Year or Dates: 1965 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Bethlehem | id Mental Hygiene. markad othar than Elementary/Secondary (0-12) College (1-4or 5+) Mill Wright 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fi and Mental It Frank H. Barnheart, Sr. Florence Follinger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Christine Prausa/Daughter 2558 Madison Ave. Union City, CA. 94587 itam 27 permit. Pages 1
Department of He
Importent: If itan
eny injury or oth 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition June 17, 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Beltsville, MD Chesapeake Crem. eake Crem. | 2009 | Delta ville, 112 | 2009 | 22. Name and Address of Facili CAFA/Stephen D.Lohrmann P.A. 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign tule of Funeral Service Licenses 8717 Green Pastures Dr. Balto, MD 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Altero sclerolic Cardio Vascular Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of) DIPCOUR **Examiner** Heart Val Vular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Probable Celebero Vascular certificate be executed anding physician and use as the burial-transi Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 Pregnant at time of death 3 ☐Ectopic pregnancy ŏ in the past 12 months? Month Day Year 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate 1 ☐ Yes 2 No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To funeral dir this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After or Attending 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number June 16 2009

State Registrar

31. Date filed (M Year)



30641

Back River Neck Rd, Ballimore 21221

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** ີ້2009 Butler 18, Ingreet R. June 10:21 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore 517 Bond Avenue Reisterstown If Under 1 Year If Under 24 Hrs Months Days Hours Min 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6 Sex 7. Age (In yrs. last birthday **Funeral** Months Days 1 M 2 T F Jan 21, 87 1922 Maryland Director 216-12-5279 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show d other than "natural", or items 23a or 28a-f shov event, fro Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director MD Baltimore Reisterstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21136 U.S.A. 517 Bond Avenue death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or iten 1 Never Married 2 Married altimore, Maryland 21215-0036 1 □Yes 2√€ No Specify If Yes Give ş 3 Widowed 4 Divorced Year or Dates White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MD Casualty 12 Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Weisheit Caroline Walter Butler ၉ other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If Item 27 Is Sister Suzanne Butler Reisterstown, MD 517 Bond Avenue 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Important: If It any Injury or out 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/22/09 Reisterstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Pleasant Grove Cem Signature / Licensee 22. Name and Address of Facility 11824 Reisterstown Road new May Eline Funeral Home Reisterstown, MD 21136 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the move of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine certificate be executed and the burial-tran resulting in death) Last Due to (or as a consequence of) 68760, physician Physician/Medical attending ph Box (IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown Ö the detached signed by t 0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? this certificate 1 □Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1**⊵**Yes 2 □ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: After (Month, Day, Year) 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death. 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

24 hours a

To the Hosp within 24 hou To the Funer completely fill

State Registrar

Medical

31. Date filed (Month, Day, Year) **JUN 19**

29a. Certifier

(Check only one)

29b. Signature and title of cartille

30. Name and address of person

Nd irlun 32. Registrar's

and manner stated.

(Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

*Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5, perfh 8894 8/31/09 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Montague J. Brackett $P^{\,\mathsf{M}}$ 5:23 2009 16 June /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore <u> Greater Baltimore Medical</u> Center Towson Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 214-031-0455 Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 XM 2 ☐ F Director 6-7-1915 214-03-04455 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, in which a least in a the ruthlind anonce. 1 ☐ Yes 2 No Funeral Director Gwynn Oak Baltimore M 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21207 2816 Greenlawn Road 12. Was Decedent Ever in U.S. Armed Forces? 1∭Yes 2 ☐ No IfYes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify. specify: African-American 34 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Insurance Agent Southern Life Ins 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bertha Brackett John Brackett 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Robinson/Daughter 2816 Greenlawn Road, Gwynn Oak, MD 21207 20a. Method of Disposition Entarement 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Arbutus Memorial Park 6-23-09 Arbutus, MD 4 ☐ Donation 5 X Other (Specify) 22. Name and Address of Facility Wlie Fineral Home P.A. of Balto. Co. 21. Signature of Funeral Service Licensee 9200 Liberty Road, Randallstown, MD 21133 23a. Patt1 Enter the disease, or complications that caused the doth. Do not enter the mode of dying, such as cardiac or respiratory arrest shoc, or heart failure. List only one cause on lack line. Approximate Interval Between Onset and Death Immediate Cause (Final respiratory **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner pheumonia if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician and for use as the burial-transi Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 3 Ectopic pregnancy Month 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by fibrillation 1 Yes 2 No 3 Probably 4 Unknown icate has been si , page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy perform this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 00 1 Nnpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes ٩ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier rson who completed cause of death (Item 23a) (Type, Print) Gosnel 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Montagu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20091 - State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Jun 200 <u>Anna May Breymaier</u> /Medical 4c. County of Death or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Roseda Baltimore Samare Birthplace (State or Foreign Country) If Under 1 Year In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Days Months 1 ☐ M 2 🕱 F Maryland 4/4/1932 Director 215-30-4611 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. Counfy 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Midcal Evan for the Indianal once. 1 ☐ Yes 2 XNo Director Baltimore Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21214 4617 Harcourt Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐Yes 2 ☒ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 XNo Specify: Specify: White by 3 ☐ Widowed 4 🛭 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Financial Receptionist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Anthony Papa ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4617 Harcourt Rd. Baltimore, MD 21214 Linda Cogswell/ Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/17/2009 Hanover, Maryland Anatamy Gifts Registry 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Joheral Service Licer 7522 Connelley Dr., Ste.P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due for as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine To the Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FFMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) certificate has been signed by the a rector, page 2 should be detached it 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 1 ☐ Yes 2 💆 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐No 2 XNo 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) director. Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Ninpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 28b. Time of Injury funeral Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 5 ☐ Pending investigation 1 Natural 2 Accident ours after death. neral Director: Af filled in by the fur 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

06.1402009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #2 Per Phy G894 8/12/09 JH
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 17 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** William T. Bensley, Jr. Sun 2000 /Medical 4a. Facility Name_(If not institution, give street and number) 4c. County of Death City, Town, or Location of Death **Examiner** 90104 3 8. Date of Birth (Month, Day, Year) 02/21/1924 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Und If Under **Funeral** Min. Days 1 X M 2 □ F Months Hours Baltimore, MD Director 215-14-0726 85 Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar is ust be notified at 1 ☐ Yes 2 No MD Baltimore Catonsville Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 707 Maiden Choice Lane Apt. 8104 21228 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. ed Forces? Yes 2 ☐ No Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: Specify: þ 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within : ment of Health and Mental Hygiene. ant: If item 27 is marked other than " College (1-4or 5+) Elementary/Secondary (0-12) Construction Carpenter 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Health and Ments tem 27 is marked William T. Bensley, Sr. Margaret (Unknown) ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any Injury or other trau once. Mr. Melvin D. Bensley (Son) 934 Barron Avenue, Essex, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 DeBurial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 06/22/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral/Service-Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Par 1. Enter the disease, or consock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Imm hiate Cause (Final **Physician** Day disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner MI Sequentially list conditions, if any leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit. resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 ☐ Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check onli one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1, Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certifier 67405 Tasaso 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CATON AVENUE ABALTIMORE MASCOD 32. Engistrar's Signature Year) 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year 5:29 PM Imore 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore OF Mari NIA 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2□ F 80 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm and call Event in a trust by mailing at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Baltimore Completed by Funeral Director Pikesville) 1 ☐ Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Prairie Rose Place 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Plack 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home College (1-4or 5+) Elementary/Secondary (0-12) Improvement Contractor 7th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Brice Ada Perkins ည 19a. Informant Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8325 Prairie Rose Place Pikesville, MD 21208 Brice Marie E. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Windsor Mill MD Vaugin C. Greene Pundat SVO 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such is rardiac or respiratory arrest,

Approximate Interval Rehyada. Immediate Cause (Final disease or condition resulting in death) **Physician** MMCIN /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to thi mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 1 No 1 ☐ Yes 2 ₩No 1 ☐ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Man of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital to within 24 hours after death.

To the Funeral Director: After a standard filled in by the fur 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number and address of person who completed cause of death (Item 23a) (Type Rosen blatt 5. Street MD 22 Greene 2/201

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Jrow1 /Medical 4c. County of Death Jown, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day) 5. Social Security Number **Funeral** 1 M 2□ F MD 213542399 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Nes 2 No Director mD timore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 6 21216 23a 2220 tuenue Funeral 14, Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 2 No 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No ō Specify Black <u>À</u> 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "n College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 then to the Health 2 140. 27 Important: If item 2 any injury or other once. 20b. Place of Disposition 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 6-26-09 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaughn C 21. Signature of Funeral Service Licenses Pike Balto. MOZNZZY Nat'1 Baltomore 5151 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Onset and Death usun Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to or as a cons vuence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician and the burial-tran Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) the 9 Unknown þ s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed? 1 ☐ Yes 2 No 2 certificate | 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only

The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records. the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Maryland 21215-0036

State 19 Registrar

one)

29b. Signature and title of certific

20 unch Murden Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

			For State		State of Ma	aryland	•					_	2000	1 /	110
			Registrar	(First Middle Le	n (1)		Cer	tificate of L	Jeatn) 	2. Date of De	Reg. No.	4007	3. Time of I)eath
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	Funeral		5. Social Security N	umber 6.	ex , 7. Age	e (In yrs. las	t birthday)	If Under 1 Year Months Days	If Under	r 24 Hrs. Min.	8. Date of Bir (Month, Da			place (State or ntry)	Foreign
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	28a-i	Director	MD 10e. Street and Nur	Washingt	con	Knoxv	7111e	10f. Zip Code				10g. Citiz	zen of What Cou	ntry?	
	3a or			ep Tryst	Road			21758				U	J.S.A.		
	death ms 2	Funeral	11. Marital Status	cp ityse	12. Was Decedent E Armed Forces?	Ever in U.S.	13. V	Vas Decedent of H Yes, specify Cuba	ispanic O	rigin? (Spe	ecify Yes or No		14. Race - Amer Black, White,		
5-0036	172 hours after death with the Maryland "natural", or items 23a or 28a-f show afterl Examinate to notified at	ρ	1 ☐ Never Marri 3 ☐ Widowed	ied 2 X Married 4 ☐ Divorced	1 ∏Yes 2 ☑ N If Yes, Give Year or Dates:	No		Yes 2 No	Specify		riidari, etc.)		Specify: Whi		
2 0	in 72 ho	Completed	(Spec	15. Decedent's Ed	ducation	- 1	16a. Deced	lent's Usual Occup	ation during mo	st of worki	na	16b. Kir	nd of Business/I	ndustry	
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7	e filed w Il Hygie other ti /ent, Il		17. Father's Name	/Eirst Middle Lasi	2		Garde	ener	18 Moth	her's Name	(First, Middle		Iscape Surname)		
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Maryland	2 should be and Mental Is marked of aumatic eve	은	19a. Informant's Na				19b. Mailin	g Address (Street					r Town, State, Z	ip Code)	
	and 2 s ealth a n 27 Is ner trau		Brian Re	ynolds/H	sband		19316	Keep Tr	yst :	Rđ. K	noxvil	le, M	D 21758		
altımore,	e te i		20a. Method of Dis		10	20b. Plac	ce of Dispos netery, cren	sition (Name of natory or other place	e)	С	ate	20c. Lo	cation - City or T	own, State	
Ĕ	Pages ment of ant: If its ury or o			\Box Cremation 3 \Box 5 \Box Other (Special	Removal from State fy)	Anat	-	fts Registr	•	_	/2009		over, Ma	·	
Balt	permit, Pages Department of Important: If i any Injury or once.		21. Signature of Fu	ineral Service Lice	ee			Name and Address							5
	Physician /Medical		23a. Part 1. Enter t shock, or hea Immediate Cause disease or condition resulting in death)	ırt failure. List only (Final	one cause in each lir	the death.	Do not ente							Approximate Interval Bety Onset and D	ween
,	Examiner	_	Sequentially list co	nditions,	b. Due to for as										
	nsit	Examiner	cause. Enter Unde Cause (Disease or	injury	a conseque	ALCOHOLOGO CI).									
,	ficate be executed physician and s the burial-transit	Exal	that initiated events resulting in death)	Last	c Due to (or as	a conseque	nce of):								
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O. Box	w requires that the death certific been signed by the attending I should be detached for use as	Physician/M	23b. Was deceden in the past 12	3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 23c. If Yes, outcome of pregnancy 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 1 □ Yes 2 No 2 □ Pregnant at time of death 5 □ Other (specify) 1 □ Pregnant at time of death 5 □ Other (specify) 1 □ Pregnant at time of death 5 □ Other (specify) 1 □ Pregnant at time of death 5 □ Other (specify) 1 □ Pregnant at time of death 5 □ Other (specify) 1 □ Pregnant at time of death 5 □ Other (specify) 1 □ Pregnant at time of death 5 □ Other (specify) 1 □ Pregnant at time of death 5 □ Other (specify) 1 □ Pregnant at time of death 5 □ Other (specify) 1 □ Pregnant at time of death 5 □ Other (specify) 1 □ Pregnant at time of death 5 □ Other (specify) 1 □ Pregnant at time of death 5 □ Other (specify) 1 □ Pregnant at time of death 5 □ Other (specify) 1 □ Pregnant at time of death 5 □ Other (specify) 1 □ Pregnant at time of death 5 □ Other (specify) 1 □ Pregnant at time of death 5 □ Other (specify) 1 □ Pregnant at time of death 5 □ Other (specify) 1 □ Pregnant at time of death 1								23d. Date of delivery Month Day Year			'ear
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r	The lar ate has page 2	Completed									24a. Was auto perf 1 □ Yes		prior to death?	topsy findings completion of c	available ause of
Vital	ysician: is certific director,	Be (25. Was case refer examiner?	red to medical				Lou		ce of Deat	n (Check only	one)			
0	Physi this o	2	1 ☐ Yes	-	Hospital: 1 ☐ Inpatie		R/Outpatier	ot 3 DOA Oth	4 🗀 1		me 5 Res 28d. Describe		6 Other (Spe	cify)	
u C	ding Phy h. After thi funeral	ion	27. Manner of Deat Natural	5 Pending investigation	(Month, Da		Injury	Wor	yaı k? Yes 2[200. Describe	now injur	y occurred		
Division	or Attending Physician: ifter death. Director: After this certific in by the funeral director,	Certification:	2 Accident 3 Suicide 4 Homicide	6 Could not be determined	e 28e. Place of Inj	ury - At hom c. (Specify)	ne, farm, str	eet, factory, office			28f. Location City or To	(Street an wn, State	nd Number or Ru	ıral Route Num	ber,
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: / completely filled in by the fi	ledical Ce	29a. Certifier (Check only one)		hysician: To the best miner: On the basis of and manner st	of examination									:)
4	To the within 2 Го the сотрые	Med	29b. Signature and	title of certifier	and manner so	ateu.)	29c. Licens	e number	r		29d. Da	te signed (Mont	h, Day, Year)	
D			Mh	1 loi	0		m	MD D	4	olt	15	6-1	6-09		
			30. Name and addi	lama	completed cause of c	m).	113	o opp	1	CT	-; t	ag	enstow	n m3	740
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Glenn S. Dawson 06-16-2009 М 1320 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center Bel Air Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthdav) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min 1 🕅 M 2 🗆 F MD 71 12-10-1937 218-34-1484 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location show the Medical Examiner must be notified at 1 ☐ Yes 2 No Darlington Director Harford MD 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ USA 21034 23a 1744 Castleton Rd by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 X Married jo, If Yes, Give Year or Dates 1 ☐Yes 2 XNo Specify White 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Utilities Foreman 10 permit, Pages 1 and 2 should be filed i Department of Health and Mental Hygin Important: If item 27 Is marked other any Injury or other traumatic event, # 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Mae Stearn Charles Dawson ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Darlington, MD 21034 1744 Castleton Rd Janet Dawson (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Baltimore, MD Bayview Crematory 06-18-2009 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home of BelAir 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Inc. 610 W. MacPhail Rd Bel Air, MD 21014 Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) AROS /Medical Due to (or as a consequence of) Examiner Severe Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-tran Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 ☐ Other (specify) □Yes 2□No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Cardiomyopathy Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe certificate 1 ☐ Yes 2 1 No 1 ☐Yes 2 ☑No Division of Vital Hospital or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🖼 🕅 0 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 June 16,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

O,

Dawson

500 upper Chesa peake Dr. Bel Air MD 24014

	Please Type or Print in Black Indelible Ink. Ensure Amend 23a per primary phys. G896 107 per Amend Item 238 per dr. 18894 18991 1769 and Health and 1-Registrar Certificate of Death	All Copies Are Lo 23/09 dk Mental Hygiene Reg. No.	egible. 2009 971 <u> </u>					
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Benjamin DeMartin 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea	2. Date of Death Month Day	Year 3. Time of Death 7 50 P M ounty of Death					
Funeral Director	FRANKLIN Square Hospital Center Rosedale 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 1 M 2 F 82 Yrs. 1 Days Hours Min	s. 8. Date of Birth	3a CTIMORE 9. Birthplace (State or Foreign Country) Mary Land					
or 28a-f show	Usual Residence of Decedent	10a. Citize	10d. Inside City Limits 1 □Yes 2 □ No					
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatil and Mential Hygiene. Department of Heatil and Mential Hygiene. To merked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evaninar must be notified at once. To Be Completed by Funeral Director	89 Coachman Drive 11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 No If Yes, 2 No If Yes, 3 No Specify: 1 Never Married 2 No Specify:	rto Rican, etc.)	USA Race - American Indian, Black, White, etc. Specify: White					
ad within 72 hours ygiene. er than "natural" t, the Medical Ext	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of work difference) (Give kind of work done during most of work difference) (Bit is not become a complete of the complete of	orking	d of Business/Industry					
should be filed and Mental Hyg marked othe umatic event,	John B. DeMartin, Sr. Kezi	me (First, Middle, Maiden Surname) ah Webster ural Route Number, City or Town, State, Zip Code)						
Pages 1 and 2 and 1 and 2 and 1 and 2 and 1 and 2 and 1 and	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State		d. 21234 ation - City or Town, State imore City, Md.					
permit. F Departm Importar any Injur	4 □ Donation 5 ☑ Other (Specify) Emtombment Gardens of Faith 6-23 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sc 9705 Belair Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardi	chimunek Funer 1 Nottingham	ral Home , Md. 21236					
≺ Physician	shock, or hearf failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pacture — Multiple Myeloma Due to (or as a consequence of):		Interval Between Onset and Death Syears 5 days					
be executed cian and cian and ciansit	Sequentially list conditions, if any leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last Due to [or as a consequence of]: Neuropathy Due to (or as a consequence of): d.		4 months					
the Hospital or Attending Physician: The law requires that the death certificate be thin 24 hours after death. The law requires that the death. The law requires that the death. The law requires that the death. The law requires that the death. The law requires that the death of the after this certificate bas been signed by the attending physici mpletely filled in by the funeral director, page 2 should be detached for use as the business of the business o	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)							
w requires that the should be defined by Pletch by Pletc	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		e contribute to the cause of death? No 3 Probably 4 Unknown 24b. Were autopsy findings available					
cian: The law requirements been sector, page 2 should	examiner?	autopsy performed? 1 Yes 2 No leath (Check only one)	prior to completion of cause of death? 1 □ Yes 2 □ No					
tal or Attending Physician: The radice death. The and Director: After this certificate held in by the funeral director, page Certification: To Be Com	examiner? 1 Yes 2 No							
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: After completely filled in by the fur Medical Certification	29a. Certifier (Check only one) Check only one) Check only one) Check only one) (Check only one) Check only one) (Check only one) (Check only one) (Check only one)	City or Town, State) ace, and due to the cause(s)	and manner as stated.					
To the within a To the comple	29b. Signature and title of certifier 29c. License number D 63.051	June	e signed (<i>Month, Day, Year</i>)					
State Registrar	30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) Najid Cina, ND, 9000 Franklin Janne Drive, Baltimore, M. 31. Date filed (Month, Day, Year) 32. Jegistrar's Signature JUN 19 2009 Liver S. Jankal	> 21201						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) .TUNE 18, 2009 6:05 A M Physician THERESA DOLL CAROLINE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** HARFORD FOREST HILL FOREST HILL HEALTH & REHAB CENTER If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 09/13/1903 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Maryland 1 ☐ M 2 🙀 F 105 214 74 4066 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examinations 23a or 28a-f show once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 ☐ No Directo Middle River Maryland Baltimore 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number USA 21220 6911 Yale Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: Black, White, etc. white 1 Never Married 2 Married 1 ☐ Yes 2XXXIII Specify: Specify: þ 3 ₩ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (unknown) (unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6911 Yale Road Middle River Maryland 21220 (daughter) Ida Doll Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 6/20/2009 | Parkville Maryland 4 ☐ Nonation 5 ☐ Other (Specify) Parkwood Cemetery 22. Name and Address of Facility Bruzdzinski Funeral Home PA re of unera Service I censee 21. Sign 1407 Old Eastern Avenue Essex Maryland 21221 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, anly one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or shoot or heart failure. List Imm-diate Cause (Final disea e of condition resulting) death) 3 WEEKS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical ending pluse as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? atten for us 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ڄ CORONARY ARRAY DISTASE 1 ☐ Yes 2 No 3 Probably 4 Unknown Mon Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No After this certificate I tuneral director, page 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Hospitai or Attending 5 Pending investigation Natural 2 🗌 No 1 ☐ Yes death. Director: / 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide completely filled in by determined after 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 29c. License number 96 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDGEWOOD, MD. 21040 1308 BUSINESS CENTER WAY -STANLEY M. KMAN 232. Registrar's Signature 31. Date filed (Month, Day, Year) State **JUN 19** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month 05 2009 Helen Ann Demby unc 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Iteal Ho If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1 □ M 2 💢 F 79 7-18-1929 212-28-0909 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 -Yes X No Balto MD Edgewood 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21040 USA 1959 Melvin Drive Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 No Specify: Black ₩ Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hospital/Housekeeping Hospitals Elementary/Secondary (0-12) College (1-4or 5+) 6th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Horace Foster Alberta Cofield 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Tonya Talbert-granddaught 1429 Old Stepney Road Aberdeen, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-29-09 Garrison Forest Owings Mills, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H la MD 21202 wa 1101 E. North Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the myse of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on a ch line. Balto, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) wee W Due to (or as a consequence of): thero sclero Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of) Due to (or as a consequence of) If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an

Physician /Medical Examiner

Physician

/Medical

Examiner

10a, State

Director

Funeral

2

Completed

Be

2

Funeral

Director

show

death with the

d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, Ite Medical Exemition

Baltimore, Maryland 21215-0036

burial-trar attending physician for use as the buria signed by the a cate has been sign page 2 should be certificate e Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica filled in by the funeral director,

The law requires that the death certificate be execut

P.O. Box 68760,

Records,

Vital

Division of

Examiner Physician/Medical \$ Completed 25. Was case referred to medical examiner? Be Certification: To 27. Manner of Death

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No

autopsy

24b. Were autopsy findings available prior to completion of cause of death?

performed 1 □ Yes 2 >

26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

28a. Date of Injury (Month, Day, Year) 28b. Time of 5 ☐ Pending investigation 6 ☐ Could not be

28c. Injury at Work? 1 ☐Yes 2 ☐No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

焰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

2 No

1 Yes

Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

29c. License number

29d. Date signed (Month, Day, Year)

200 FAC address of person who completed cause of death (Item 23a) (Type, Print) 1308

and manner stated.

100 2. Registrar's Signature 31. Date filed (Month, Day,

State Registrar

within 24 hor To the Fune completely f

4

DHMH 17 Rev 1/2001

the

determined

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 Year 4:12 17, Рм June Erna Elene Dickerson 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 10010 Lodge Road Baltimore 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
April 18,1932 West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Min. Months Days Hours April 214-34-4692 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore MD Baltimore 1 ☐ Yes ※☐ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21234 USA 10010 Lodge Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ★ Married white 1 ☐ Yes 2 XNo Specify: <u>م</u> Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BBL Cockeysville Media Maker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mae Church Worther England ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10010 Lodge Road-Baltimore, Maryland 21234 19a. Informant's Name/Relationship (Type. Print) Lester Harold Dickerson-spouse 20b. Place of Disposition (Name of Dullaney Cornellory Control of Place)
Memoorial Gardens 20a. Method of Disposition Date 20c. Location - City or Town, State June 19,2009 Timonium, Maryland N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8800 Harford Road 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
EVANS FUNERAL CI
AND CREMATION SI CHAPEL SERVICES modiae home faolol Parkville,MD 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) monyas un cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 □Yes 2 ⊟No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

permit. Pages 1 and 2 sl
Department of Health an
Important: If Item 27 Is I
any injury or other trau **Physician** /Medical Examiner Examiner sician and burial-transit The law requires that the death certificate be execufed P.O. Box 68760, signed by the attending physician d be detached for use as the buria Physician/Medical Division of Vital Records, ð Completed peen s page 2 s has this certificate the Hospital or Attending Physician: Be မ within 24 hours after upcar.

To the Funeral Director: After this Certification: 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Wand Kley 6/18/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

Physician

Examiner

Funeral

Director

show

death with

within 72 hours after

12 should be filed within 7 th and Mental Hygiene.
7 is marked other than "n

Baltimore, Maryland 21215-0036

Director

Be

ortant; If Item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, the Medical Examination until be notified at

/Medical

Wends /Cloese 31. Date filed (Month, Day, Year)

Kloese



Kenwork

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Bal. France

2/266

09-04323	
Bruce Fleming	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Bruce Fleming	State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg.	No. 2009 19718
Physician/	Registrar 2. Date of Death	3. Time of Death
Medical Examiner	24 20	9 1033 HIS
15	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	4c. County of Death
-1	University Hospital Baltimore	Dangard O Bidhalago (State or
Funeral	S. Social Security Number 1. Social Security	MM/DD/YYYY) 9. Birthplace (State or Foreign
Director	012-46-0424 1x M 2 F 55 Yrs. Months Days Hours Nov. 17	, 1953 Country) MA
	Usual Residence of Decedent	10d, Inside City Limits
v any	10a. State 10b. County 10c. City, Town or Location	1 Yes 2 No
Maryland 28a-f show d at once. ector	MD Cecil Port Deposit	. Citizen of What Country?
the Maryland a or 28a-f sh tified at once	10e. Street and Number 10f. Zip Code 10g	
3a or otific		USA 14. Race - American Indian, Black,
er death with or items 23 rmust be no Funeral	11. Marital Status 1 Never Married 2 Married 2 Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	White, etc.
or its	1 Yes 2 X No November 1 Yes Give Year 1 Yes 2 X No specify:	Specify: White
s afte rral", niner by	or Dates: 15 Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done	16b. Kind of Business/Industry
hour hatu	Elementary/Secondary (0-12) College (1-4 or 5+)	
36 hin 72 than dical	12 Truck Driver	Transportation
5-0036 ed within 72 hour tygiene. tygiene. the Medical Exar	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Mail 18. Mother's Nam	aiden Surnäme)
215 be file that H rked o ent, th	William Reid Fleming Lois Ruth Beard	lsl e y
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "matural", or items 23a or 28a-f sho injury or other traumatite event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Numb	
MD 12 sh th and th and umat	Ferris Reid Fleming, Sr. / Brother 332 Mt. Hope St., N. Attlebor	20c, MA 02760
Te, l and l Heal	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) North Purchase 6 11 00	200, Education - Oily of Form, State
Pages ent of r oth	4 Donation 5 Other Specify: Crematory 0-11-09	Attleboro, MA
Baltil Permit. Departm Importa injury o	21. Sign rure of Funeral Service Licensee 22. Name and Address of Facility Dyer-Lake I	
M E A E E	161 Commonwealth Ave, N. A	Attleboro, MA ()2/6()
Physician	234. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest failure. List only one cause on each line.	Between Onset and Death
/Medical Examiner	Immediate Cause (Final disease a <u>Multiple injuries</u>	
	or condition resulting in death) Due to (or as a consequence of):	
Ď.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
i i	cause. Enter Underlying Cause c.	
ted Insit Examiner	events resulting in death) Last Due to (or as a consequence of):	
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0, e be execut ysician and burial - tra		23d. Date of delivery
68760 certificate nding phy se as the b	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	Month Day Year
x 60 h cert tendin use a	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	A A
. Box 6876 the death certificate by the attending phy ched for use as the I Physician/IM	1 Yes 2 No 9 Unknown 9 Unknown	pacco use contribute to the cause of death?
Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Eurora Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the indicinal Certification: To Be Completed by Physician/IM.		
S, P		n 24b. Were autopsy findings available
cords law requestable has been seen seen to a should	autops perform	prior to completion of cause of
Records, The law require ficate has been signage 2 should b.	1 ✓ Yes 2	
tal Recicion: The certificate rector, page	25. Was case referred to medical	
Viting by side	1 Ves 2 No I I I I I I I I I I I I I I I I I I	now injury occurred
n of V	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe h	fell from a truck
tend teath. tor:	Pending 5/29/2009 Fd 10:37 pm 1/2 yes 2 No 3d5/3000	
Division of Vital Records, P.O. Division of Vital Records, P.O. ours after death. reral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach. Certification: To Be Completed by P	2 A Accident investigation (See. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (See. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (See. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (See. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (See. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (See. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (See. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (See. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (See. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (See. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (See. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (See. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (See. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (See. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (See. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (See. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (See. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (See. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (See. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (See. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (See. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (See. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Loca	treet and Number or Rural Route Number City Late Breyers/Good Humoric Iant 1100 Frederick St
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in Leading Control Certifical Cer	4 Homicide determined (Specify) 4 Homicide 4 Homicide 4 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause (Check only) 5 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause of completing and/or investigation, in my online, death occurred at the time, date.	OWII, MD
D To the Hospital within 24 hours completely filled	Consider the lime, date and place, and due to the best of my knowledge, death occurred at the time, date and place, and due to the best of my knowledge, death occurred at the time, date and place, and due to the best of the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the best of the be	and place, and due to the cause(s)
To the Ho within 24 To the Fu completel	and manner stated. 29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
	22D. Signature and title of continuous	June 3, 2009
Cor a		
6 oral	30. Name and a dress of person who completed cause of death (Item 23a) Ling Li, MD . Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
	20/Penistrat's Signatura	
Stat Registra		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10:20 A.M June 2009 Brenda Foster /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Good Samaritan Hospital Baltimore n/a 8. Date of Birth (Month, Day, Year 02-07-1944 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 □ M 2 1 F 219-40-7972 65 MD Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director M) n/a Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6 USA 23a 1631 Northeate Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11. Marital Status 1 ∏Yes 2∭ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: specify: African-American þ permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", any Injury or other traumatic account. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dietician Baltimore City Public School 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Parrish Johnson Annie Cotton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Andrew Foster Jr./ Hisband 1631 Northeate Road, Baltimore, MD 21218 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Arbutus Memorial Park 6-24-09 Arbutus, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. ge of Funeral Service Licensee 9200 Liberty Road, Randallstown, MD 21133 Phil 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** To conduct disease or condition resulting in death) /Medical to (or as a consequence of): Examiner HEROSCHEPOTIC Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due o (or as a consequence of): Examine certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. ð 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ER/Outpatient 3 ☐ DOA ၉ 1 ☐ Inpatient funeral (27. Manner Death 28a. Date of Injury (Month, Day, Year) ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After t Certification: 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Momicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only the To the within 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 2009 17, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

JOSEPH

31. Date filed (Month, Day, Year)

JUN 19 2009

DHMH 17 Rev 1/2001

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ach raven but bactmore mo 21239

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M.D. 32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. < 1. Decedent's Name (First, Middle, Last) 2. Date of Death CHARLES G. FINDLEY, JR. Ĩ5 11:39P™ JUNE 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE RIVERVIEW NURSING HOME BALTIMORE COUNTY Trunder 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. Sept. 20, 1922 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) PA. 1 → M 2 □ F 215-16-5326 86 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes X2X No Marvland Baltimore Baltimore County 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21206 USA 419 Meadow Rd. 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Nes 2 No WW11
If Yes, Give
Year or Dates: 1 Never Married XX Married White 1 □Yes 2XXNo Specify 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Bethlehem Steel Corp. Foreman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lelia V. Marsh Charles G. Findley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 23 Col. Daniels Dr. Bedford, New Hampshire 03110 Paul D. Findley (Son) 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 6-19-2009 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) ature of Funeral Service Licensee 22LMrssaffida Fufferal Home 7401 Belair Rd. Baltimore, Md. 21236 2820m Approximate Interval Between Onset and Death 23a. Part 1. Enter the discrete, or complications that caused linshock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) ovenery Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Ye ar Day in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide

Physician /Medical Examiner

Physician

/Medical

Director

Funeral

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Physician/Medical

Completed by

Be

Certification: To

Medical

Examiner

Funeral

Director

Department of Health and Mental Hygiene. Important: If Item 23a or 28a-f show important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Item Madical Extures a must be mailled at

death with the Maryland

72 hours after

should be filed within

1 and 2 s

Pages 1

Maryland

Saltimore,

burial-trar for use as the page 2 should certificate director. this

Physician: The law requires that the death certificate be executed funeral o After t Hospital or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death.

Division of Vital Records, P.O. Box 68760,

10+1

DHMH 17 Rev 1/2001

State

EBASTIAN 31. Date filed (Month, Day, Year)

29a. Certifier

29b. Signatur

(Check only one)

JUN 19 2009

29c. License number 00055171

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 06/16

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3023

and manner stated.

32. Registra s Sign

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 06 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 2004 /Medical 4c. County of Death **Examiner** Baltimore City enter Social Security Number Irauma Date of Birth (Month, Day, Year) Jan. 6, 1926 9. Birthplace (State or Foreign last birthday) Age (In yrs. 1 ☐ M 2 ☐ F Months Days Hours Maryland 219-22-8751 Vrs Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 10a. State 1 □Yes 2X No Baltimore County Director Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21162 6121 Ebenezer Rd. Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No White Specify: 2 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaking -Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Ripke John T. Bowers ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3582 Conchita Dr. Ellicott City, Md. 21042 Diane L. Feruson (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place)
HOLLY HILL M. G. 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Md. 6-18-09 4 ☐ Donation 5 ☐ Other (Specify) re of Funeral Service Licensee ²²Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 Hor Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Immediate Cause (Final Subdural Week Hemotomo disease or condition resulting in death) Due to (or as a consequence of): STATE AND INTERPRETATION OF MEDICAL PLANTS Sequentially list conditions, frame detections, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown barachnoid Hemorrhage Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐Yes 2 ☐No 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? 1☐1es 2☐No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Naturat 5 Pending investigation 1 ☐ Yes 2 ☐ No PAL From Standing
28f. Location (Street and Number or Rural Route Number,
City or Town, State) 2 Accident 6-5,2009 UNKnown 6 ☐ Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Box 68760. P.O. cate has been signed by page 2 should be detact Records, certificate Division of Vital this After the Funeral Director. After Anderson in 24 hours are the Funeral Director. completely within 2.

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Wedical Exergine and be notified at

item 27 r other ti

permit. Pages Department of Important: If it any Injury or c

Physician

/Medical

Examiner

State

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

GEORGE C. KUCHMAN IT

JUN 1 9 2009

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

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NPI

29c. License number

1255590147

0336 CadorLW,

Baltimore

Columbia

29d. Date signed (Month, Day, Year)

esidence

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32. Registrar's Signatu

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and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ye*a*r **Physician** 12:04 PM OLIVER FRIEDMAN 15 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital of Baltimore Baltimore N/A Cit If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 05/10/1919 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 X M 2 □ F 105-12-7711 90 NY Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Exaction of the traumatic event, the Modical Exaction of the following the content of the modical Exaction of the following 10b. County 1 ☐ Yes 2 X No Director MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21117 4730 ATRIUM COURT, APT.#124 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 DYes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or ite 1 ☐ Never Married 2 💢 Married **Maryland 21215-0036** 1 ☐ Yes 2 💢 No Specify. Completed by Specify 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) MANUFACTURER WOMEN'S CLOTHING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FRIEDMAN မ IRVING LENA SCHNEIDERMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BEVERLY FRIEDMAN / WIFE 4730 ATRIUM CT., #124, OWINGS MILLS, MD 21117 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ XBurial 2 ☐ Cremation 3 ☐ Removal from State OHEB SHALOM MEM. PARK 06/18/2009 REISTERSTOWN, MD 4 Donation 5 DOther (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service License 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2 years Cancer una /Medical Due to (or as a consequence of): Examiner 010 Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed to hours after death. signed by the attending physician and d be detached for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) I ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension 2 🗌 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of gause of death? 24a. Was an has 2 2 No 2 1 No 1 Tyes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ Mo 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Matural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R25-0000 June 15th 2000

State Registrar 31. Date filed (Month, Day,

Sihai

32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 16,2009 **Physician** Rita P. Gallagher 6:18A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Holly Hill Nursing, LLC Towson Balto. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Date of Birth (Month, Day) **Funeral** Year) Months 1 □ M 2 1 F Days Hours Yrs 192-14-4597 23,1922 Pennsylvania 86 Director August Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla D. partment of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once. M☐Yes 2☐No Director Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3521 Woodstock Avenue 21213 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 ∭ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo White þ Specify: 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Francis Andrews Mary Kennedy ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14145 Anastasia Lane Orlando, Fla. 32828
of Disposition (Name of Date 20c. Location - City or Town, State Neal Gallagher, Jr. Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer 6-19-2009 Baltimore City,Md. 21. Signature of Funeral Service Licensee Schimunek Funeral Home 9705 Relair Rd. Nottingham, Md. 21236 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** years disease or condition resulting in death) stroke /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ypertension Due (as a consequence of): Examiner Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Dav 5 ☐ Other (specify) ☐Yes 2☐No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s 1 ☐Yes 2 ☑No 1 □ Yes 2 1No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred spital or Attending P nours after death. neral Director: After t y filled in by the funera 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Touk

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2055 **Physician** 2001 UNE 16 Mary Lee Gaither /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner | Randallstown | Ba | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Baltimore Seasons Hospice at Northwest Hospital Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X Director 09/05/1944 NC 212-44-4732 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expansion rate to cutfied at once. 1. Yes 2 No Director MD Brooklyn Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21225 Funeral 901 Cherry Hill Rd. Apt. 157 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify: If Yes, Give Year or Dates: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Health Care Elementary/Secondary (0-12) College (1-4or 5+) Caretaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Susan Johnson 2 Harvest Love 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cherry Hill Rd. Apt. 157 Brooklyn, MD 21225 Henry Gaither/Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jun 18 2009 Beltsville, Maryland Chesapeake Crematory Inc. 21. Signafture of Funeral Service Licensee 22. Name and Address of Facility MOILYS Cremation and Funeral Alternatives 2 Baltimore, Maryland 21286 8717 Green Pastures Drive 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** END STAGE COMONIC LYMPHOLYTIC LEVICOMIA /Medical Due to (or as a consequence of): **Examiner** Se juentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 5 Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 № No 24a. Was an autopsy performed? Be

Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, After this certificate has been signed by the funeral director, page 2 should be detached

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after death in by the

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within 2 To the I

Baltimore, Maryland 21215-0036

25. Was case referred to medical examiner? 26. Place of D Other: 4 \(\sum \) Nursing Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

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eath (Check only one)	
) Home	5 Residence	6 Dother (Specify) SUDSV (C)
280	L Describe how ini	ury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Debbie

Smith Avonue Suite 205 Baltimoro MD 2835 Burton

State Registrar

Certification: To

Medical completely

29a. Certifier

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Joseph E. Goulden 11:00 AM 06 15 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Bel Air, Maryland Upper Chesapeake Medical Center Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day Year) 05/31/1925 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours Min 1**X**M 2□ F Pennsylvania 84 Director 179-20-8671 Usual Residence of Decedent 10d. Inside City Limits 10b County 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 □Yes 2XNo Funeral Director Baltimore MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. 21236 8 Dunhaven Place 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2X No Specify Specify: Completed by 3 XWidowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Baltimore County Animal Control Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel Overholtzer John Vincent Goulden 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health Important: If item 27 any injury or other the 27 Christine McCann (daughter) 1724 Indian Court - Hampstead, Maryland 20c Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Aloysius Ch.Cem. 06/19/2009 Littlestown, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. re of Funeral Service Licensee 11750 Belair Road - Kingsville, Maryland 21087 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Stage Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐Yes ØXNo 1 □Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Impatient 2 ER/Outpatient 3 DOA 1 Tes this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours a er death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D60768 - Chesapeake Dr. Bel Air, MD 21014

Registrar DHMH 17 Rev 1/2001

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82. Registrar's Signature

30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print) Tokkedar

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31. Date filed (Month, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Mary		artment of Hea rtificate of De			0000	10700	
			Registrar 1. Decedent's Name (First, Middle, Last)		Tillcate of De		2. Date of Deat		3. Time of Death	
	Physicia /Medic		Louise Helman				June June	Day Year 16, 2009	10:00 a ^M	
·	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Lo	ocation of Death		4c. County of Deat		
Variable .			8715 1st Ave. Apt. 918 5. Social Security Number 6. Sex 7. Age (In	n yrs. last birthday)	Silver Sp		R Date of Birth	Montgome:	hplace (State or Foreign	
ы	Funeral Director		182-16-6308	88 Yrs.		Hours Min.	B. Date of Birth (Month, Day,	Year) Co	PA	
	D		Usual Residence of Decedent						10d. Inside City Limits	
	show	٥		c.City,Town or Loc silver Sp1					1 □Yes 2 No	
	the N	Director	10e. Street and Number		10f. Zip Code		11	0g. Citizen of What Co	untry?	
	h with		8715 1st Ave. Apt. 918		20910		1	USA		
	r deat	Funeral	11. Marital Status 12. Was Decedent Ever Armed Forces?	in U.S. 13. V	Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (Spec Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Ame Black, White		
36	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show ifical Eval, in request be motified at	by F	1 Never Married 2 Married 1 □ Yes 2 No If Yes, Give 3 □ Widowed 4 □ Divorced 1 □ Year or Dates:		1 □Yes 2 No S	Specify:		Specify: W	nite	
21215-0036	2 hou latura ical E		15. Decedent's Education	16a. Decer	dent's Usual Occupation	on		16b. Kind of Business/	industry	
21	within 7 iene. than "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	_	kind of work done duri DO NOT use retired) ecretary	ing most of working	,	Federal Government	-	
d 21	filed w Hygie other tl	S	17. Father's Name (First, Middle, Last)			8. Mother's Name	First, Middle, M			
Maryland	ld be lental ked o	To Be	John Helman			Edna Sch	nenck			
lary	2 should and Men is marke raumatic	-	19a. Informant's Name/Relationship (Type. Print)		-			, City or Town, State,		
	1 and 2 Health em 27 Ither tr		Neil Schenck, nephew			1 Road; N		ille, PA 1:		
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Mudical Event in 11st be notified at anone.		1 Burial 2 Cremation 3 Cremoval from State		esition (Name of matory or other place)					
altin	permit. Po Departme Importan any Injury once.			and the second second	e Cemetery 2. Name and Address			Branch Twp l & Cremat:		
ä	Depar Depar Impor any Ir		1 Many Cas					g, MD 2091		
			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not ent	ter the mode of dying,	such as cardiac or	respiratory arr	est,	Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Congestiv		Failure					
4	Examiner		Due to (or as a co	nsequence of):						
	± ⊄	ner	Sequentially list conditions, if any, leading to immediate cause. Erric U.Griying, Cause (Disease or injury	nsequence of):				9		
	kecute and Ftrans	Examine	Cause (Disease or injury that initiated events c							
68760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and raid director, page 2 should be detached for use as the burial-transit	alE	d							
89	rtificat ng phy as the	Medical								
Вох	eath certific attending p for use as f	an/N	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of p	Fetal death 3	Ectopic pregnancy			23d. Date of delivery Month Day Year		
0	at the de by the a tached f	Physician/M	1 ☐ Yes 2 No 4 ☐ Pregnant at tim 9 ☐ Unknown	e of death 5L	Other (specify)					
ď.	s that med by e deta	by Ph	Part II. Other significant conditions contributing to death but no	ot resulting in the un	nderlying cause given	in Part I.	23e. Did tol	bacco use contribute t	o the cause of death?	
ords	w requires been sign should be		Atrial Fibrillation				1 □ Ye	es 2□No 3XP	robably 4 Unknown	
Vital Records,	law re has be	Completed	Hypertension				24a. Was a	sy prior to	utopsy findings available completion of cause of	
аі Е	lan: The l rtificate hator, page		Valvular Heart Disease					2 2 No 1 □ Ye	s 2□No	
Z:	yslclan: is certific director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	2 🔲 ER/Outpatier	Other:	6. Place of Death	- 4	ence 6 □Other (Spi	ecify)	
	ding Phy h. After thi funeral o	on: To	27. Manner of Death 11 Natural 5 Pending (Month, Day, Ye	28b. Time of				ow injury occurred		
siol	or:	catic	2 Accident investigation		M 1□Ye	s 2 No	06 1 60		lum / Davida Alumban	
Division	after de Direct	Certification:	4 Homicide determined 28e. Place of Injury - building, etc. (5	At nome, farm, str Specify)	eet, ractory, office	2	City or Town	treet and Number or R n, State)	urai Houte Nurnber,	
	To the Hospital or within 24 hours after To the Funeral Directory Completely filled in b		29a. Certifier (Check only 2 Medical Examiner: On the basis of examiner)							
	the Ho nin 24 the Fu	Medical	one) and manner stated							
	or with	2	29b. Signature and title of certifier	La lu	29c. License n			29d. Date signed (<i>Mon</i>	un, Day, 18al)	
			30. Name and address of person who completed cause of death	1 (Item 23a) (Type.	D2580	0		0/1//2009		
_			Herman Speigal 10313 Georgia			, MD 209	10			
	Sta Registr		31. Date filed (Month, Day, Year) 22. Registrar's	Signature						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar amend 25 per Dr.g892 6/19/Opertification of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 3rd May 2009 Houston 20104 /Medical 4b. City, Town, or Location of Death
Baltimore Baltimore Facility Name (If not institution, give street and number) Examiner Honore Birth Month, Days Hours Min (Month, Day, Year) Medica Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 res 2 No MD Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S. 21224 View Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black. White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Blac Specify. Saltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) INfant Elementary/Secondary (0-12) College (1-4or 5+) INFANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Kosua har les 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21224 Ba Way Houston ew 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State athedra1 7-31-09 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bradley 21. Signature of Eugeral Service Licensee WHERRI Home, 14 2134 1100 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) prematuri extreme **Physician** Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner burial-transit Hospital or Attending Physician: The law requires that the death certificate be execut Due to (or as a consequence of): ota えつ Division or Vital Records, P.O. Box 68760, been signed by the attending physician should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 ☐ Probably 1 🗌 Yes 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed deatn : 1 ∐ Yes 2No 10 Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2☐ No 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Mann eath 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? After t (Month, Day Year) 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 24 hours after death. e Funeral Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide filled in by determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 24 the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DEA AU4176435P19176

State

31. Date filed (Moritin, Day, Year) JUN 05 Registrar

Meognosia

Papasozomenos Registrar's Signature

301

Name and address of person who completed cause of death (Item 23a) (Type, Print)

St. Raul

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St. Baltimore

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2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day hamffett **Physician** 4:10 AM M Catherine <u>1</u>3 2009 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Joseph Richey Hospica Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 💢 F 72 Dec 8, 1936 Director 136-28-6169 New Jersey Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County iral", or items 23a or 28a-f show Fxaminer must be notified at MD Baltimore 1 Yes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1143 Horners Lane 21205 <u>USA</u> Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: white δ 3 T Widowed 4 □ Divorced d other than "natural", event, It's Medical Exp Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) licensed practical nurse <u>healthcare</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Lewis Mowell Theresa Ruth Ballis မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr Catherine Burnett/daughter 613 2nd Avenue Plattsmouth, NE 68048 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Ronald State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 2.a. Pat 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirth, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Cause (Final disease or andition resulting in death) Physician BreasT METASTATIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Ö 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Minknown Failu Heart Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Disease 1 ☐Yes 2 ☐ No Obstr Chronic 1 ☐ Yes Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 2 No Hospice 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Umbalance: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatur and title of certifier 40062554 June 13, 2009 DO 30. Name and address of person who completed cause of death (Item 23a) (Typr Print Let Cynth: A Shen, DO 838P North Est Horpiae 21201 Baltimore, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 1 9 2009 Registrar

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09-03901 Steven Jones

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day May 16, 2009 1008 hrs Medical Examiner Steven Jones c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Salisbury Wicomico 924 East Isabella Street If Under 1 Year If Under 24Hrs. 9. Birthplace (State or 5. Social Security Number unk 6. Sex 8. Date of Birth (MM/DD/YYYY) 7. Age (In yrs. last birthday) **Funeral** unk Days Min Months Hours Director Country) 42 Apr 3, 1967 1 X_M 2 Yrs Usual Residence of Deceden 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County Yes 2 X No or 28a-f show MD Wicomico Salisbury or items 23n or 28a-f show must be notified at once. with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 924 E. Isabella Street 21801 USA 12. Was Decedent Ever in U.Sun 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 14 Race - American Indian, Black, unk White, etc. 1 Never Married 2 Married Yes Give Year Divorced Yes 2 X No specify. Widowed 4 or other traumatic event, the Medical Examiner white item 27 is marked other than "natural", 2 16a. Decedent's Usual Occupation (Give kind of work done unk 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk Completed during most of working life. DO NOT use retired) more, MD 21215-0036
Pages 1 and 2 should be filed within 72 h
nent of Health and Mental Hygiene Elementary/Secondary (0-12) College (1-4 or 5+) unk 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk unk Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ۵ O.C.M.E. Penn Street Baltimore, MD20a. Method of Disposition 20h Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, crematory or other place) 2 Cremation 3 Removal from State important: 22. Name and Address of Facility
State Anatomy Board
21201 Donation 5 X Other Specify: in state ice Licensee 21. Sign to re of Funeral Sen irector 655 W. Baltimore Street 23a. Part i. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva **Physician** Between Onset and failure. List only one cause on each line /Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease **xaminer** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Physician/Medical AMENDED 23a, 27, perME, g892 6/22/09 TT XUNPENDED signed by the attending physician be detached for use as the burial. Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth 3 Ectopic pregnancy Month Day Fetal death past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. è Yes 2 No 3 Probably 4 🗸 Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available this certificate has been autopsy prior to completion of cause of death? performed' Yes 2 1 🗸 Yes Νo 26 Place of Death (Check only one) 25. Was case referred to medica director, Be Other; examiner? Hospital: 1 Nursing Home 5 Residence 6 V Other: Scene 2 ER/Outpatient 3 Inpatient မ 1 ✓ Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Yes 2 No Pending To the Funeral Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

IIIN 19

Ling Li, MD

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

and manner stated.

32 Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

May 17, 2009

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 38 PM Samuel Johnson 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town or Location of Death Examiner Hunzita 17 imore General Jary land If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**∑**IM 2□ F 63 249-78-3383 Nov 20, 1945 Maryland Director Usual Residence of Decedent 10d Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10h. County 28a-f show 1√ Yes 2 No MD Baltimore must be notified Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ō 2614 Park Heights Avenue 21215 or Items 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 167-71 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: black ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry Injury or other traumatic event, the Medical 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 0 record keeper city of Baltimore and Mental Hygie is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Sammy Johnson Clarissa Robinson ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any Injury or other trau once, Lena Johnson/spouse 2614 Park Heights Avenue Baltimore, MD Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5☒Other (Specify) in state 21. Signature of Funeral Service Licensee Ronald S, Wade, ²² Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Patt1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Sause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical **Examiner** 200070 Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 □Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 TYes 2 🗆 No 2 No 25. Was case referred to medical examiner?
1 ▼ Yes 2□ No Be 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA ို this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28h Time of 27. Manner of Death 28c. Injury at Work? After Certification: Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death Director: in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide To the Hospital of within 24 hours af To the Funeral D completely filled in 1 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUN 19

e and address of person who completed cause of death (Item 23a) (Type, Print)

2009

32/Registrar's Signature

29c. License number

D0063086

Mora Cax Genera

29d. Date signed (Month, Day, Year)

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 11:05 Havanah J. Kenlaw June 2009 p. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Hospice Towson Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min 1□M 2ĂF 11-12-1945 229-56-2546 63 Director Usual Residence of Decedent 10d. Inside City Limits should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, I'm Medical Examinat must be notified at 1 □Yes 2 No Baltimore Reisterstown Director 10g. Citizen of What Country? 10f. Zip Code 21136 10e. Street and Number 1 Folly Farms Court USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married specify: African-American Maryland 21215-0036 1 ☐ Yes 🎾 No Specify: ð 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Public School Principal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ellie Mae Lewis Horace D. Jefferson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important; If item 27 is any injury or other trau once. 1 Folly Farms Court, Reisterstown, MD 21136 Robert Kenlaw/ Husband Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 6-22-09 Ruther Glen, Va Jefferson Family Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. nature of Funeral Service License 9200 Liberty Road, Randallstown, MD 21133 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DLI OBLASTOMA Winters **Physician** MULTRAME disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.O. been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ò 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy page perform 1 ☐Yes 2 ☐ No 1 ☐Yes 2 No certificate To the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical director Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After the funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Division Natural 5 Pending within 24 hours after upon 17 the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

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(Check only 29a. Certifier Medical 29c. License number \$8303 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles ST M

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			For State Registrar	State of Marylar	•	irtment of H tificate of L			iene _{eg. No.} 200	9 19734
	Dhi.i		Decedent's Name (First, Middle, Last)					2. Date of Deat	Day Year	3. Time of Death
44	Physicia /Medic		Louis Henry Linds					June 16	,2009	5:51 P. M
	Examin	er	4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or Kingsv	Location of Death		4c. County of Dea	
Н	Funeral		2439 Loloa Drive 5. Social Security Number 6. Sex	7. Age (In yrs.	. last birthday)	If Under 1 Year_		8. Date of Birth		thplace (State or Foreign
	Director		212-30-0501	^{M 2□ F} 76	Yrs.	Months Days	Hours Min.	December	9. Bir 30, 1932	Maryland
	ww		Usual Residence of Decedent 10a, State 10b, County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	-f sho	tor				ry Hall				1 ☐ Yes 2 ☐ No
	r 28a	Director	Md. Balto. 10e. Street and Number		161	10f. Zip Code		1	0g. Citizen of What Co	ountry?
	23a c		9511 A Kingscroft	Terr		21128	3		USA	
036	72 hours after death with the Maryland "natural", or items 23a or 28a-f show "neat Ever instrongs be rodified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Ever in U Armed Forces? 1 MYes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of Hi fYes, specify Cuba I □Yes 2 No		ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whit Specify: W	
Maryiand 21215-0036	be filed within 72 hor stal Hygiene. d other than "natura event, Ire Prosice.	Completed	15. Decedent's Educa (Specify only highest grade	ation co <i>mpleted)</i>	16a. Deced	dent's Usual Occup kind of work done of OO NOT use retired	ation during most of work	ing	16b. Kind of Business	/Industry
717	filed within 72 Hygiene. other than "nat	ошр	Eiementary/Secondary (0-12)	College (1-4or 5+)		ce Techn:			BGE	-
פַ	al Hygi other vent, I	Be C	17. Father's Name (First, Middle, Last)		, , , , , ,		18. Mother's Name	e (First, Middle, M	faiden Surname)	
Z		10	Louis H. Lindner					E. Hans		
	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type Ken Lindner	e. Print) Son	1	ng Address (Street a			City or Town, State, , Md. 210	
Baltimore,	Pages 1 annent of Herint: If item		20a. Method of Disposition 1	moval from State	Place of Dispo cemetery, cren laney V	sition (Name of natory or other place Valley	e) 6-19-		20c. Location - City or	
Ralt	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licensee			. Name and Addres	ss of Facility Sch	imunek I	Funeral Horam, Md. 21	me 236
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the dea	th. Do not ent					Approximate Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition	SQUAMO	us C	ell C	greins	ma	Skad+	Onset and Death
	/Medical Examiner		resulting in death)	Me to (or as a consec	quence of):					/
	ted sait	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a sones	quence of):					
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O. Box	death certi e attending ed for use a	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 [Ectopic pregnancy Other (specify)	У		23d. Date of de Month	elivery Day Year
rds, P.	requires that the neen signed by the	by P	Part II. Other significant conditions control	ributing to death but not re	sulting in the ur	nderlying cause give	en in Part I.	23e. Did tol	10000	to the cause of death? Probably 4 🗆 Unknown
I	The larate has page 2	Completed						24a. Was a autops perforr	y prior to ned2 death?	autopsy findings available completion of cause of
VItal	Physician: this certific ral director,	Be (25. Was case referred to medical examiner?	on Mali		l out	26. Place of Deat	h (Check only on		
=	his la	.T	1 Yes 2 No	1 ☐ Inpatient 2 ☐	ER/Outpatier		4 LI Nursing Ho	ome 5 Reside	ence 6 EDAR (S)	esidence
0	th. : Afte	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury	Work	(? Yes 2 □ No	Zou. Describe ne	W mary occurred	
UIVISION	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funera	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Spec	nome, farm, str ify)	eet, factory, office		28f. Location (St City or Town	reet and Number or F n, State)	Rural Route Number,
	e Hospita 24 hours e Funera letely fille	edical C		clan: To the best of my kn er: On the basis of examin and manner stated.						
)	To th withir To th comp	Me	29b. Signature and title of certifier	May 22 mg		29c, License	e number	2	9d. Date signed (Mor	nth, Day, Year)
				SICK METELS N	שני	D00	47762		6/18/9	1
			30. Name and address of person who com	The state of the s		Print)	monium	n MD	21093	
	Sta Registr		31 Date filed (Month, Day, Year) JUN 1 9 20	32. Registrar's Sign	ature .	barris				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Amend Item 23aPtI,,25 per me, 893.07/01/09dhb Registrar Registrar Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 4:55 p^M 2009 Keith A. Lewis 6 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Balto Future Care If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 □XM 2 □ F 213-60-3653 3-16-1953 MD Director 56 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Exambles in the marting of the context the Marical Exambles. 1X Yes 2 □ No Director MD N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21213 U S Α 1403 Montford Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 Mo If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify Specify: Black <u></u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City College (1-4or 5+) Elementary/Secondary (0-12) Laborer 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Lewis ပ Eunice Jennings 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Eunice Lewis-Mother 1403 Montford Avenue Balto, MD 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Pk 6-20-2009 Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Lice e March East F/H MD 21202 North Avenue Balto, 1101 Ε. 23a. Part 1. Enfer the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Cerebral Aneurysm APPROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and CERTIFICATION Due to (or as a consequence of) attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 3 Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 2 No 1 ☐ Yes 2 🕡 1 ☐ Yes Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica 25. Was case referred to edical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Mann f Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Matural 5 Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of the caus 29a. Certifier Medical nd/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) PNG 31. Date filed 32. Registrar's

Registrar DHMH 17 Rev 1/2001

State

Division of Vital Records, P.O. Box 68760

		Physici /Medi Examin Funeral irrector
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland	Department or heart and weather hygerer. Important: If Item 27 is an extended the Important: If Item 27 is an extend other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.
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or Vital Records, P.O. Box 68760,	ysician: The law requires that the death certificate be executed	his certificate has been signed by the attending physician and idirector, page 2 should be detached for use as the burial-transit

			For State Registrar	State 5. III	ar y rairia i	Cer	tificate of			Reg. No	עטט"	19100
ľ	2 0		1. Decedent's Name (First, Middle, L	ast)					2. Date of De Month	ath Da	v Year	3. Time of Death
	Physicia /Medic		Helen Annette Lys	en Annette Lyston					June 18		009	5:30 AM M
	Examin	er	4a. Facility Name (If not institution, gi	ive street and number)			4b. City, Town, o	r Location of Deat	h	4c	. County of Death	n
24). 		911 East Seminary 5. Social Security Number 6.		hirth dou	If Under 1 Year	owson If Under 24 Hrs.	8. Date of Bir		altimore	nplace (State or Foreign	
	Funeral Director			1 M 2 X F	e (In yrs. last 79	Yrs.	Months Days	Hours Min.	(Month, Da	y, Year)	Cou	untry)
*			236-46-0390 Usual Residence of Decedent		13				11/15/	1929		
	rylan how		10a. State 10b. County		10c. City, T	own or Lo	cation					10d. Inside City Limits
	e Ma Sa-f s tiffed	cto	MD Baltimo	re	Towso	n						1 □ Yes 2 No
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	s 23a		911 East Seminary			1	21286			USA	14. Race - Amer	vices Indian
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5	Irs af	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	••		1 ☐ Yes 2 🗖 No	Specify:			Specify: Whit	t-0
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7	filed within 72 hours after death with the Maryland Hygiene. wther than "natural", or items 23a or 28a-f show wther the Medical Examiner must be notified at	Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. L	kind of work done DO NOT use retired	during most of wo. d)	rking	Own	Home	
7	ed wi ygien ier th it, the	Con	12		H	lome 1	Maker					
2	be fill	Be	17. Father's Name (First, Middle, Las	st)					me (First, Middle		1 Surname)	
Š	d Mer narke	은	Merrill Newcomb 19a. Informant's Name/Relationship	/Time Brint)		10h Mailin	ng Address (Street		olsombac		as Taura Ctata 3	Pin Cadal
2	id 2 s ith an ith an traul		Frank Lyston/Husba	,			last Semi:					.p code)
ນົ	s 1 ar f Hea ftem 2		20a. Method of Disposition				sition (Name of matory or other place		Date		ocation - City or	Town, State
2	Page: nent o nt: If		1 ☐ Burial 2 【Cremation 3 4 ☐ Donation 5 ☐ Other (Spec				e Cremat	1	Jun 19 2009	Belt	sville,	Marvland
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lice	ensee $ u$	01442	22	2. Name and Addre	ss of Facility				
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1	/Medical Examiner		resulting in death)	Due to (or as	a consequen	ice of):						
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Š	ath ce ttendii or use		23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth	pf pregnancy 2 ☐ Fetal de		∃Ectopic pregnanc	y		100	23d. Date of del	ivery Day Year
5	sician: The law requires that the death ce certificate has been signed by the attendi rector, page 2 should be detached for use	Physician/I	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of deat	h 5□	Other (specify)			1	WOITH	Day Teal
Ŀ	that the set by detacl		Part II. Other significant conditions	contributing to death b	ut not resultir	ng in the u	nderlying cause giv	ren in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
ecords,	signe d be	Completed by	multipl		100	-			10	Yes 2	2 □ 11 0 3 □ Pr	robably 4 □Unknown
5	w req	lete		<i>(</i>					24a. Was	an	24b. Were at	utopsy findings available
ב ה	he la e has age 2	dmc							auto perf	psy ormed?	prior to death?	completion of cause of
g	an: T	0	25. Was case referred to medical					26. Place of De	1 Yes ath (Check only	2.□N one)	6 1 □ Yes	2 □ No
>	nysici nis cer direc	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatie	ent 2∏ER	l/Outpatier	nt 3 DOA Oth	or.			6 ☐Other (Spe	cify)
5	ng Pł fter tł neral		27. Manner Death 1 Tatural 5 Pending	28a. Date of Inju (Month, Da	y Year)	3b. Time o	f 28c. Inju	ry at rk?	28d. Describe	how inju	ury occurred	
2	tendleath.	catic	2 Accident investigati 3 Suicide 6 Could not	he				Yes 2 ☐ No				
>	or At ifter d Direct in by	Certification:	4 Homicide determine	d Zoe. Place of Inj	ury - At home c. <i>(Sp</i> ec <i>ify)</i>	e, farm, str	reet, factory, office		City or To			ural Route Number,
	spital ours a neral filled		29a. Certifier 1 Certifying I	Physician: To the best	of my knowle	edge, deat	h occurred at the ti	me, date and place	e, and due to the	e cause(s) and manner as	s stated.
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	(Check only 2 Medical Ex one)	aminer: On the basis o and manner st	f examination	n and/or in	vestigation, in my	opinion, death occ	curred at the time	, date a	nd place, and due	e to the cause(s)
	To th withir To th	Me	29b. Signature and title of certifier	_			29c. Licens				ate signed (Mont	
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			30. Name and address of person wh	6		3a) (Type,	Print)	n a	2	-		109 u21204
₩.			31. Date filed (Month, Day, Year)		ar's Signatur	/ e	2100	25 4 R	0_ 1	00	1500/	UD
	Sta Registr		JUN 1 9 2009	Beneva 32. Hegisti			,					
			OUIT A & ZULLY	L. M. M. W.	Jul . 100	Carried Street, or other Designation of the last of th						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #18 & 19b, per FH G893 7/6/09 T1

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3, Time of Death . 200<u>9</u> JUNE 16, **Physician** DOUGLAS JAMES METTA 9:15 AM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** MONTGOMERY BETHESDA NATIONAL INSTITUTES OF HEALTH If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Aug 31, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1**∑** M 2□ F 032-46-8541 37 1971 Massachusetts Aug **Director** Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b County show of Health and Mental Hygiene.
Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, it a fix-allocal Examinar mass to incitive at 1 ☐ Yes 2 ☑ No Director VA Loudoun Ashburn 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21747 Omeara Terrace Apt. 203 20147 USA Funeral hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Specify: White <u>م</u> 3 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Executive Chef Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If item 27 Is marked oth any injury or other traumatic event Be Adele Adela MacKoul Albert Metta ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Emeara Terrace Kimberly Metta (Wife) Apt. 203 Ashburn, VA 20147 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/22/09 Mt. Benedict Cemetery Boston, MA 4 Donation 5 Other (Specify) 21. Signatus of Funeral Service Licensee 22 Name and Address of Facility Kroury-Keere Funeral Home 8 Spring St. West Roxbury, MA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): /Medical **Examiner** Securificity list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due/to (or as a consequence of): law requires that the death certificate be executed Exami the burial-tran and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical as nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy for Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 ☐ Other (specify) detached 9 Unknown 9 Unknown ģ signed l d be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown , page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 □ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2)X No Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director; ₱ 2 Accident the 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D67974 (MD) -ROCHO 30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

Registrar

V

State

PARIZAD TORABI PARIZI, MD

31. Date filed (Month

Barra

gistrar's Signature

10 CENTER DRIVE, BETHESDA, MARYLAND 20892

09-04611 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. William Mcleran State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day June 10, 2009 Medical Examiner William Scott McLeran 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1507 East Joppa Road #108 **Baltimore County** Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign **Funeral** If Under 1 Year Days Months Director 213-52-7996 01/06/1951 1 X M 2 58 Usual Residence of Decedent 10b. Count 10c. City, Town or Location Important: If iten 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the <u>Medical Examiner must be notified at once.</u> hours after death with the Maryland Director 10e. Street and Number 10g Citizen of What Country? 21234 Funeral 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 No 4 Divorced f Yes. Give Yes 2 No Yes specify à 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) be filed within 72 l of Health and Mental Hygiene. Baltimore, MD 21215-0036 NG 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname Be Pages 1 and 2 should ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 3 20a. Method of Disposition Place of Disposition (Name of cemetery, Date crematory or other place) 2 Cremation 3 Removal from State NE Donation 5 Other Specify 21. Signature at Funeral Service Licensee 400 Part I. Enter the disease, or somplications that caused the death. Do not enter the mode of dying, **Physician** failure. List only one cause on each line /Medical a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease **€**xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last physician and the burial - transi Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth be detached for use as past 12 months? 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð Chronic obstructive pulmonary disease, diabetes mellitus Completed director, page 2 should certificate has been 24a, Was an autopsy performed' Yes 2 25. Was case referred to medica 26.Place of Death (Check only one Be examiner? Hospital: Other₄ 2 Inpatient 2 FR/Outpatient DOA Nursing Home 5 After this 1 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? Certification: ✓ Natural Pending Yes 2 To the Funeral Director: in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide determined Homicide 29a. Certifier

Town, State 20c. Location -F.17 5%. Approximate Interval such as cardiac or respiratory arrest, shock, or heart Between Onset and Death 23d. Date of delivery Day Month Year 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 ✔ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 🗸 Yes No Residence 6 V Other: Scene 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E June 10, 2009 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 **ORIGINAL**

Year

0913 hrs

Md

10d. Inside City Limits

14. Race - American Indian, Black,

Yes 2 LNo

State Registrar

Medical

29b, Signature and title of certifie

Melissa Brassell, MD

Assistant Medical Examiner

31. Date filed (Month, Day, Year)

09-04810	
Mary Mitchell	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Mary Mitchell	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No.	09 19739						
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year June 17, 2009	3. Time of Death 1455 hrs						
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of D 4s. County of D 4s. County of D 4s. County of D 4s. County of D							
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9 246 34 6209 1 Months Days Hours Min. 12/01/1928	Birthplace (State or or oreign North Country Carolina						
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits						
<u> </u>	Maryland Baltimore Essex	1 Yes 2 X No						
th the Maryland 23a or 28a-f she notified at once al Director		Country?						
er death wi	Armed Forces? I Never Married 2 Married Armed Forces? I Yes 2 X No Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.	merican Indian, Black, tc. White						
5-0036 ed within 72 hours aft tygiene. other than "natural" the Medical Examine Completed by		·						
21215-0036 uld be filed within 72 Mental Hygiene. marked other than 'e event, the Medical To Be Comple		Alle						
21215. Ould be filed d Merked of searched of tice event, the To Be C	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S							
more, MD 212: Pages I and 2 should be ent of Health and Menta tut: If item 27 is marke r other traumatic even To Bg	James L. Mitchell (son) 1241 Engelberth Road Essex Maryland 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - Cit							
Baltimore, MI permit. Pages I and 2. Department of Health a Important: If item 27 injury or other traum	1 X Burial 2 Cremation 3 Removal from State crematory or other place) A Donation 5 Other Specify: Maryland Veterans Cen 6/29/2009 Garrison	Forest, Md						
Balt permit. Departi Import	2 Shrietur of Funcial Service Licensee 22. Name and Address of Facility Bruzdzinski Funera. 1407 old eastern Avenue Essex MAry.							
Physician Vedical aminer	23a. Pat I. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. In mediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease	Approximate Interval Between Onset and Death						
Adminier	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.							
red only	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated c.							
nd transit	events resulting in death) Last Due to (or as a consequence of): d.							
50, te be executed ysician and burial - transit		ivon						
D. Box 6876: the death certificate by the attending phy teched for use as the I Physician/M	23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 1	Day Year						
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Records The law requirate has been apage 2 should	24a. Was an autopsy prior deal 1 Yes 2 No 1	e autopsy findings available to completion of cause of th? Yes 2 No						
Vital F ysician: ysician: this certific director,	25. Was case referred to medical examiner? Hospital: 4 Inspiral: 4	Other: Scene						
on of \ ending Phy ath or: After tt the funeral \text{the funeral } tion: Te	27 Manner of Death 28a Data of Injury 28b Time of Injury 28c Injury at Work? 28d Describe how injury occurred							
Division of ospital or Attending hours after death hours after death birector: After a filled in by the fune Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rural or Town, State)							
To the Hospi within 24 hou To the Fune completely fi	_ 1 29a, Ceruller 4 6 . 47 , 50							
A S T S D D D D D D D D D D D D D D D D D	29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed June 18, 2009	(Month, Day, Year) 9						
1	30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201							
State Registrar	te 31. Date filed (Month, Day, Year) 32. Registrar's Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 19741

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			nts Ave N of Fa		ibot)		Pikesville					re Count	
Funeral		5. Social Security	Number 6. S	ex 7	'. Age (In yrs. las	t birthday)	If Under 1 Year Months Days		_	of Birth(N		Foreign	ace (State or
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y		Usual Residence	of Decedent 10b, County		10c. City, T	own or Location	on .						od. Inside City Limits
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arylanc 8a-f sh at onc	Director	10e. Street and N	lumber				10f. Zip Code			10g.	Citizen of W	hat Country	/?
ith the Maryland 23a or 28a-f show any notified at ouce.		8822	Churc					1133	0 'f . Va	a or No			n Indian, Black,
be a	Funeral	11. Marital Status	rried 2 Marrie			i. 13. Wa:	s Decedent of His es, specify Cubar	spanic Origin? (3 n, Mexican, Puerl	to Rican, e	tc.)		ite, etc.	
er deal	Ē	3 Widowed		1 Yes ed If Yes, Give Year	2 X , No	1 🔲	Yes 2 No	specify:			Specify		ick
ours aft atural' camine	d by	- 1,	Education (Specify	or Dates:	e completed)	16a. Deceden	t's Usual Occupa ost of working life	tion (Give kind o	f work don etired)	e 1	6b. Kind of E		
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5-0036 iled within 7 Hygiene I other than	Completed by		Grade	st)	4			18.Mother's Nar	me (First, N	Aiddle, Ma	iden Surnan	ne)	
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alt alt		20a, Method of D		141110	20b. P	lace of Dispos	sition (Name of ce		Date		20c. Locatio	n - City or T	own, State
W		1 Burial	2 Cremation 3	Removal fro	om State	rematory or ot	her place)	eteni O	d241	09	Wa	dlav	in, MD
Baltimor permit. Pages Department of Important: If	1	4 Donation 21. Signature of	5 Other Speci Funeral Service Lic		18.40	22. 1	Name and Addres	ss of Facility V	ana	mc.	Green	se Pu	neral sys
Balti permit. Departi Import	1	1 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	chin C.	110		18	728 LH	certy-F	coad	Kal	naay	STOWN	Approximate Interval
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kamine		Immediate Caus or condition res		a. Multiple Inju	Uries consequence of	f):							
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Box 68760, e death certificate be execute the attending physician and	Medical	IF FEMALE:			outcome of preg	nancy						e of delivery	
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at the d	۵ ۵		ignificant condition	ns contributing t	to death but not r	esulting in the	underlying cause	e given in Part I.					the cause of death?
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Recorded The la	Dage 7						0.0 F	ace of Death (Ch		✓ Yes	2 No	1 🗸 Y	es 2 No
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of Viting Physic	Tuneral director, page	27 Manner of	2 No Death	28a. Date	e of Injury	28b. Time o		njury at Work?	28d.	Describe I	now injury or	ccurred ch struck	fixed object and
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	/ tilled in by			(Gp. 1.1)	/ Local Stre	dan dooth occ	curred at the time	date and place.	and due t	o the caus	e(s) and ma	anner as sta	ted.
To the Ho within 24 To the Fu	completely	29a. Certifier (Check only one) 2 29b. Signature	✓ Medical Exam	iner: On the basis	of examination	and/or investig	gation, in my opin	nion, death occur	red at the	time, date	and place, a	and due to t	he cause(s)
To	con	29b Signature	and title of certifier	and manner	stated.		29c. Lic	ense number			29d. Date	signed (M	onth, Day, Year)
		Pate	ill.	- Poli	21	M	O.	C.M.E.			June 1	7, 2009	
3			address of person v		use of death (Ite	m 23a)	111 Pann	Street, Balti	more M	1D 2120	1		
			Aronica-Pollak		stant Medical Regis rar's Signa				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
Rec	Sta	.~	(Month, Day, Year)	9 2009	Meneria .	1 4.	barker						

OCME

09-04245

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 William McMillion 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day May 28, 2009 0835 hrs Medical Examiner William McMillion 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** 341 Sputh Monroe Street 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State orunk If Under 24Hrs. 5. Social Security Number unk 6. Sex 7. Age (in vrs. last birthday) If Under 1 Year **Funeral** Foreign Country) Months Days Hours Min Aug 7, 1953 55 Director 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County any 1 X Yes 2 No Baltimore with the Maryland Director 10g, Citizen of What Country 10e. Street and Number 10f. Zip Code 21223 USA 341 S. Monroe Street 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status unk White, etc. Armed Forces? unk 1 Never Married 2 Married Yes 9 Specify white Yes 2 X No specify: f Yes, Give Year after Widowed 4 Divorced Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural",
injury or other traumatic event, the Medical Examinez. 2 16a. Decedent's Usual Occupation (Give kind of work done ${\tt unk}$ | 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) unk unk 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 111 Penn Street Baltimore, MD O.C.M.E. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition tant: If it, or other to crematory or other place) Burial 2 Cremation 3 Removal from State Donation 5 X Other Specify: 22 Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street gn wre of Euneral S ryice Licensee injury irector Raltimore MD 21201

It I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and re. List only one cause on each line Medical Death a Atherosclerotic cardiovascular disease Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed AMENDED 23a,2/,permE, g892 6/22/09 TI and Physician/Medical X UNPENDED attending physician or use as the burial Box 68760 23d. Date of delivery IF FEMALE: 23c. If ves. outcome of pregnancy Year Month Day 23b. Was decedent pregnant in the Ectopic pregnancy Live birth Fetal death Pregnant at time of death Other (Specify) 5 signed by the atte 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. No 3 Probably 4 ✔ Unknown þ Yes 2 Completed 24b. Were autopsy findings available 24a. Was an director, page 2 should has been prior to completion of cause of autopsy death? performed? No Yes 2 1 🗸 Yes certificate 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Be Other₄ examiner? Residence 6 V Other: Scene Hospital: Nursing Home 5 DOA Inpatient 2 ER/Outpatient 3 this 1 V Yes ဂ္ 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death Certification: 1 X Natural Yes 2 No Pending hours after death. the Funeral Director: upletely filled in by the 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 29, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Pamela E. Sputhall, MD

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

31. Date filed (Month, Day, Year)

JUN 1

9 2009

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32. Registrar's Signature

Physician Medical Examiner Ab. City, Town, or Location of Death Harford	974
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23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause [Fine] Immediate Caus	
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of the	
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29a. Certifier 29a. Certifier 29a. Certifier C(heck only one) 29a. Certifier C(heck only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, 1) 29d. Date signed (Month, Day, 1)	cause(s)
Taughtellam 10 026233 6/16/09	Year)
30. Name and address of person who completed cause of death (Item 23a) (type, Print)	15

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #11 per Inf G902 4/7/10 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 14 2009 9:46 A D June /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel VO's Chantilly Lace Assist Living Odenton Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 1 M 2 □ F 224-26-8544 86 10/4/1923 Virginia Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 1 ☐Yes 2 🗙 No Director Anne Arundel Odenton MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. 21113 537 Queen Anne Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. þ 3 Widowed Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within 7 rent of Health and Mental Hygiene.

11: If item 27 is marked other than "n y or other traumatic event, the Medi College (1-4or 5+) Elementary/Secondary (0-12) Health Care Nursing Assistant 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Unknown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 1013 Lake Wood Dr. Colonial Heights, VA 23834 Hazel Williams/ Niece 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pages
Department o
Important: If any injury or
once. 6/16/2009 Hanover, Maryland Anatomy Gifts Registry 4 XDonation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Lio-7522 Connelley Dr., Ste.P, Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Failure to Thrive **Physician** disease or condition /Medical Due to (or as a consequence of) Examiner End Stage Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed sician and burial-trans Due to (or as a consequence of) physician s the burial P.O. Box 68760 Physician/Medical attending p 23d. Date of delivery ves, outcome of pregnancy 23b. Was decedent pregnant Live birth 2 Fetal death 3 🗌 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) 4 Pregnant at time of death ☐Yes 2☐No ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Hypertension, Diabetes Mellitus, Hyperlipdemia 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 2 🔀 No 2 No certificate 1 □Yes Division of Vital 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Assist. Living 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death Certification: After 1 Injury Hospital or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: completely filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide e Funeral I 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 6/15/2009 D0063145 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 705 Digital Dr. Linthicum, MD 21090 M.D. Arvind Desai 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar JUN 19

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienery 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 200 110:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3809 Baker Avenue Harford Abingdon 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 1, 1910 7. Age (In vrs. last birthday) **Funeral** Min. 1 M & F Months Days Hours 216-05-0501 98 Director Usual Residence of Decedent 10d. Inside City Limits death with the Marylan 10a State 10b. County 10c. City. Town or Location th and Mental Hygiene. ?7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at MD Harford Abingdon 1 ☐Yes 2 X No Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21009 USA 3809 Baker Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 ₩ Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At Home 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Antonina Anello Francisco Collurifici ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3809 Baker Avenue-Abingdon, Maryland 21009 Pete Pasta- son permit. Pages 1 and Department of Health Important: If item 27 any Injury or other trong. 27 20b. Place of Disposition (Name of cemetery, crematory of other place)
Dulaney Valley
Memorial Cardens 20c. Location - City or Town, State 20a. Method of Disposition June 20,2009 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
EVANS FUNERAL CHAPEL
AND CREMATION SERVICES 8800 Harford Road Parkville,MD 21234 LTYE Jak 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nmediate Cause (Final Immediate Cause (r disease or condition resulting in death) **Physician** /Medical Due to (or 1/14) nsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse Examine a Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Proneal Director: After this certificate has been signed by the attending physician and sician and burial-trans Due to (or as Division of Vital Records, P.O. Box 68760, Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months' Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 ☐ Yes 2 No 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? /es 2 40 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred o medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) No 1 ☐ Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 104 Pegistrar's Signatu State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 🗸 U Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 14, 2009 June Joseph Charles Prince 3:50 P /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** n/a 3420 Wilkens Avenue Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 🔀 M 2 🗆 F 212-44-3946 6/8/1942 Maryland Director 67 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State r than "natural", or items 23a or 28a-f show 1X Yes 2 □ No n/a Baltimore Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with 21229 USA 3420 Wilkens Avenue Funera 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Mayes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify. White δ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Retail Food 12 Store Manager 12 should be filed with and Mental Hygier 17 Is marked other the event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be .. Pages 1 and 2 should be tment of Health and Menta tant: If item 27 is marked fury or other traumatic er George Prince Agnes Suchbradl 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3420 Wilkens Ave., Baltimore, MD 21229 Elsie Prince / Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Department of Important: If it any injury or c 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetary 6/18/2009 Baltimore, Maryland 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4107 WIlkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final month **Physician** Tancreatic Carcinoma disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami the death certificate be executed burial-transi that initiated events and resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 been signed by the attending physician should be detached for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Day Year 5 Other (specify) ⊒Yes 2 □No 9 Unknown The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Funeral C 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 5+1 and manner stated To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and thie of

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Mont

D 26817

10 N Greene St.

MD

1D VAMC
32/Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert A Barthel MD VAMC 10

09

Baltimore

Amend #30 per DVR 8892 6/19/09 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 3:30 PM Price James 2009 16 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deat 4b. City, Town, or Location of Death **Examiner** N/A If Under 24 Hrs. Date of Birth (Month, Day 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country)
 A 1 **Funeral** Hours Min Months 1 **X**M 2□ F Days 19.26.712 05 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaniner must be notified at once. 10b. County 10a State 1 Yes 2 No Baltimore Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 619 ucia Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 res 2 ☐ If res, Give Year or Dates: 2 No 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: 3 Widowed 4 □ Divorced Be Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Health l'are Engineer echnical 12th Orade 17. Father's Name First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lanter EWamae ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) lifmar Road Windsor Mill MD 21244 Powell Connie Daugh Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison 26/09 Owings Mills, MD Forest 4 ☐ Donation 5 ☐ Other (Specify) Vaugno C. Greene Funeral sucs 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Randallstown MD 21133 Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician (1) days /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Day Month Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, ģ Path MI 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed certificate 1 ☐Yes 2 No 1 ☐ Yes 2 🗷 No Division of Vital funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1-Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 29c. License number 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H · AHMED 821 N. Eutaw St, Suite 103 Baltimore, MD 21201 31. Date filed (Month, Day, Year)
JUN 1 9 2009 Registrar's Signature State Registrar

09-04184	
Brian Pugh	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

rian Pugh	1- For State	Maryland / Department o <i>Certificate</i> o		/giene Reg. N	2009 197	1.				
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)			2. Date of Death	3. Time of Death	_				
Medical Examiner	Brian Pugh 4a. Facility Name (if not institution, give stre	pet and number)	4b. City, Town, or Location of Death	May 27, 2009	4c. County of Death	_				
	Mercy Hospital	set and numbery	Baltimore							
Funeral Director	5. Social Security Number $\mathbf{u}\mathbf{n}\mathbf{k}$ 6. Sex 1 \mathbf{X} M	7, Age (In yrs. last birthday) 2 F 49 Yr	If Under 1 Year If Under 24Hrs. Months Days Hours Min.	_	M/DD/YYYYY 9. Birthplace (State or Foreign Countr Maryland					
any	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loca	ation		10d. Inside City Limit	s				
<u> </u>	MD Politimore									
the Maryland o or 28a-f show iffed at once.		eet	10f. Zip Code	10g. C	itizen of What Country?	_				
with the Maryland ns 23a or 28a-f sho be notified at once. eral Director	1423 Patapsco Aven		21230		USA					
hours after death with the Maryland 'natural', or Items 23a or 28a-f she Examiner must be notified at once eed by Funeral Director	11. Marital Status 1 X Never Married 2 Married	Armed Forces? If	as Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc.					
safter de ral", or niner mu by Fu	3 Widowed 4 Divorced If Your	Yes 2 X No	Yes 2 X No specify:		Specify: white					
hours fratur Exami	15. Decedent's Education (Specify only hi	during r	ent's Usual Occupation (Give kind of wonds of working life, DO NOT use reti		b. Kind of Business/Industry					
5-0036 led within 72 hours after thygiene. other than "natural", the Medical Examiner Completed by I	Elementary/Secondary (0-12)	College (1-4 or 5+)	disabled		none					
5-0036 liled within Hygiene. I other that the Medic Compl	17. Father's Name (First, Middle, Last)		18.Mother's Name	(First, Middle, Maide	· ·					
2121; Muld be fill Mental H marked c event, I	Logan Pugh 19a. Informant's Name/Relationship (Type,	Print \ 10h Mailir		y Mitchel		_				
VID 21 2 should h and Me 27 is ma Imatic ev	Betty Pugh/mother	142:	ng Address (Street and Number or F Stree 3 Patapsco Avenue	t -Baltimor	e, MD 21230					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than higury or other traumatic event, the Medica To Be Comple	20a. Method of Disposition 1 Burial 2 Cremation 3 F		osition (Name of cemetery, other place)	Date 20	c. Location - City or Town, State					
limo Page ment o tant: or oth	4 Donation 5 X Other Specify: 1	n state								
Ball permit Depar Impor	21. Sign / re of Funeral So ice Licensee	ide Offector St	Name and Address of Facility Late Anatomy Boar	d 655 W.	Baltimore Street					
Physician	23a. Par I. Enter the disease, it convinces that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and									
/Medical xaminer	Immediate Cause (Final disease a. N.	arcotic and alcoho	l intoxication		Death	u				
	b	to (or as a consequence of):								
iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause									
ted nsit Examiner	(Disease or injury that initiated C	to (or as a consequence of):								
'60, cate be executed oblysician and be burial - transit	d.	#101 D T-6 0	1902 (12/100 TH			_				
60, ate be es hysiciar e burial	XUNPENDED X AT	MENDED #19bePer Inf G	a.27.28a-f per MI	E g893 7/1	23d. Date of delivery					
687 ertific ding p	23b. Was decedent pregnant in the past 12 months?	Live birth 2 F	etal death 3 Ectopic pregna		Month Day Year					
Box e death c the atten ed for us	1 Yes 2 No 9 Unknown		Other (Specify)							
P.O. B s that the d gned by the e detached by Phy	Part II. Other significant conditions cor	cco use contribute to the cause of death?								
rds, P.C requires that been signed I hould be deta	<u> </u>			1 Yes 2	No 3 Probably 4 Unknown 24b. Were autopsy findings availate	_				
of Vital Records, ng Physician: The law requires ther this certificate has been signeral director, page 2 should be To Be Completed	·			autopsy performed	prior to completion of cause of death?					
	25. Was case referred to medical	· · · · · · · · · · · · · · · · · · ·	26.Place of Death (Check		No 1 ✓ Yes 2 No					
of Vital ing Physician: After this certificaneral director,		tal: 1 Inpatient 2 ER/Outpatien	nt 3 DOA Other'4 Nursin	ng Home 5 Res	sidence 6 Other:					
- E - N 21 X	27. Manner of Death 1 Natural 5 Panding	28a. Date of Injury (Month, Day,Year) 28b. Time of		28d. Describe how unk	injury occurred					
Division Is after death. al Director: A led in by the fu	2 Accident Investigation	Fd 5/24/09 unk 28e. Place of Injury - At home, farm, str	1 Yes 2 X No		et and Number or Rural Route Number, Ci	itv				
Division o spital or Attending ours after death. neral Director: Aft filled in by the fune Certification:	3 Suicide 6 X Could not be determined	et and Number or Rural Route Number, City e) 1215 S. Hanover St e, MD								
	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
To the Hos within 24 h To the Fur completely	one) 2 Medical Examiner:On and 29b. Signature and title of certifier	the basis of examination and/or investig manner stated.	29c. License number		old. Date signed (Month, Day, Year)	_				
_ *	1 11	14	O.C.M.E.		lay 28, 2009					
	30. Name and address of verson who com	pleted cause of death (Item 23a)				-				
		ef Medical Examiner 111 Pe	enn Street, Baltimore, MD 2	1201		_				
State Registrar	31. Date filed (101), 13,9°2009	82. Registrar's Signiture								

DHMH 17 Rev 1/2001

ORIGINAL

OCME

			For State Registrar	State	e of M	arylan		artment rtificate			and M	ental Hy	gien Reg. No	200	9	19749
		1. Decedent's Name (First, Middle, Last) Physician [Medical Hildegard Emma Gisela Raabe]											e of Death 3. Time of Death			
													Month Day Year 17, 2009			6:55 PM
4	Examin		4a. Facility Name (If not institut	ion, give street and	d number))		4b. City, T	own, or Lo	ocation	of Death		4c. County of Death			
2			401 Russell Av	e #509					hers		,			ontgo	mery	7
	Funeral		5. Social Security Number	6. Sex 1 □ M 2 ■			last birthday) Yrs.	If Under 1 Months		If Under Hours	Min.	8. Date of Bir (Month, Da	th ly, Year,) 9	Cour	
	Director		289-28-6328 Usual Residence of Decedent		<u> </u>	85	115.					12/30/1	1923	G	erma	any
	ow i		10a. State 10b. Count	ty		10c. City	y, Town or Lo	cation							1	0d. Inside City Limits
	Mary a-fsh	ţċ	MD Mont	gomery		Gait	thersb	ırg								1 □Yes 2 No
3	or 28	ire	10e. Street and Number					10f. Zip (Code				10g. C	itizen of Wh	at Cour	ntry?
	23a	Funeral Director	401 Russell Av	e. #509				2087						many		
	tems tems	nue	11. Marital Status	Arme	d Forces?		S. 13.	Was Decede f Yes, speci	ent of Hisp fy Cuban,	anic Ori Mexicar	igin? (Spe n, Puerto f	cify Yes or No Rican, etc.)	-	14. Race - Black,	Americ White,	
00 3	ori	by F	1 Never Married 2 Ma	1 Never Married 2 Married 1 Yes 2 No 1 Yes, Give 3 WWidowed 4 Divorced Year or Dates:				1 ∐Yes 2 ≰ No <i>Specify:</i>						Specify:	Wh	ite
200-	itural	ed					16a. Dece	ecedent's Usual Occupation					16b. H	Kind of Busi	ness/In	dustry
<u>ו</u>		plet	(Specify only highest grade completed) (G				e kind of work done during most of working DO NOT use retired)								•	
7	giene er tha	Completed	Liementary/Secondary (0-12)	Ho				emaker			vn Home					
2	be fled within 72 hours after death with the maryland vial Hygiene. vial Hygiene. do other than "natural", or items 23a or 28a-f show event, the "color! Evans in court be notified.	Be (17. Father's Name (First, Middle	e, Last)					18	8. Mothe	er's Name	(First, Middle,	, Maidei	n Surname)		
<u> </u>	Men Marke	၉	Wilhelm Otto				1	Lucie Emma Marie Gras								
Na	th and 7 is n traun		19a. Informant's Name/Relation	nship (Type. Print))							iRouteNumb arket,				Code)
ָׁ ע	Healt Healt Healt Hem 2		Hans A. Raabe, 20a. Method of Disposition	son		20b. P	Place of Dispo					ate ate		ocation - C		own, State
₫ ,	ent of ht: If it y or o		1 ☐ Burial 2 🗷 Cremation 4 ☐ Donation 5 ☐ Other (rom State		emetery, crer esapeal				119/	2009	Re1	tsvi1	1e.	MD
	perfilit. Fages I and 2 should be filed within 72 hours after death with the Marylan death-much Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "crical Examination of the multiple and once."		21. Signature of Funeral Service	· · · · · · · · · · · · · · · · · · ·	MO	1539	22	. Name and	Address	of Facilit	Rapp	Funera			-	on Svcs.
בֿ בֿ	Depa Impo any I		Meny C	at								r Spri				
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between										Interval Between			
P	hysician		Immediate Cause (Final disease or condition Metastatic Adenocarcinoma									Onset and Death MOS •				
	/Medical xaminer		resulting in death) Due to (or as a consequence of):													
	.xue.	7.	Sequentially list conditions,	b	o to (or ac	2 0000000	ioneo of):								-	
40.0	nsit	min	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events												- 41	
,	ial-tra	Examine	that initiated events resulting in death) Last C. Due to (or as a consequence of):													
or ou,	physician and s the burial-transit	dical														
	ing ph	Med	IF FEMALE:													
	attending p	sician/Me	23b. Was decedent pregnant in the past 12 months? 1								23d. Date of de Month			ery Day Year		
5	the a	ysic													54,	
	ned by the	, Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute							oute to t	he cause of death?					
3	n sign	d by	Scleroderma 1 □ Yes 2 ▼ N							2 No 3	No 3 Probably 4 Unknown					
	s peen s	lete	24a. Was an 24b.								24b. W	Vere autopsy findings available				
Completed Comple								perfo	autopsy prior to completion of cause of performed? death?							
	this certificate I	Be C	25. Was case referred to medic	al					2	26. Place	of Death	1 ☐ Yes (Check only o	2 X N one)	0 1 1		2 2 1140
hveir	his ce	2	examiner?									(y)				
, ,	h. After th funeral	on:	27. Manner of Death 1 1 Natural 5 Pending (Month, Day, Year) 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Work? 28d. Describe how injury occurred Work?													
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (specify) 23d. Da Mc 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (specify) 23d. Da Mc 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (specify) 23d. Da Mc 23d										and Alumba	er or Rural Route Number,					
										te)						
chita	neral y fillec		29a. Certifier 12 Certify	ring Physician: To	the best	of my kno	wiedge, deat	n occurred a	it the time	, date a	nd place,	and due to the	cause	(s) and man	ner as	stated.
A HO	in 24 l he Fu pletel)	Medical	29a. Certifier (Check only pine) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									o the cause(s)				
Ę.	vith To t	Ž	29b. Signature and title of certifier 29d. Date 29c. License number 29d. Date 20d. Date 20d. Date 20d. Date 20d. Date 20d. Date 20d. Date 20d. Date 20d. Date 20d. Date 20d. Dat								Date signed (Month, Day, Year)					
			Jole 12 Milwely My 1)19294 Ju							une 14, 2009						
			30. Name and address of perso						21124 -	MT	2007	R				,
	Sta	te	John R Melnic 31. Date filed (Month, Day, Yea.	r) 3	32 Registr	rar's Signat	ture		burg,	, FID	2007	-				
	Registra	4	JUN 192	009 am	ne	A.	bar									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 2:15 PM Iris Hope Ronaldi 2009 June 16 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hertiage Harbour Health & Rehab. Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🔀 F Director 091-30-0261 4/21/1939 New York Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Anne Arundel Churchton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20733 U.S.A. 'natural", or items 23a 5627 Gunner Run Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2**X**]No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 🔀 No Specify Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Retail Merchandising Bridal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Health and Mental em 27 is marked o George Zack Estelle Braqman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5627 Gunner Run Rd. Churchton, MD 20733 Department of Health Important: If item 27 any Injury or other to once. Thomas Ronaldi/ Husband 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/17/2009 Hanover, MAryland Anatomy Gifts Registry 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licensee 7522 Connelley Dr., Ste.P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause A each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 2 DNo 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred ...er death. I Director: Afr in by th 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ical (Check only

Box o of Vital Records, Division Hospital or Attending

21215-0036

Baltimore, Maryland

Registrar

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	ate of Maryland	/ Depa	artment		alth and M	ental Hyg	liene n n q	1975	5 l			
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	uncate	OIDE	aui	2. Date of Dea	eg. No.	3. Time of [Death			
	Physici			uernagle, Sr.					Month	8, 2009 Year	10:03	A ^M			
	/Medic Examin		4a. Facility Name (If not institution, give stree			4b, City, 7	Town, or Loc	cation of Death	Julie 1	4c. County of Deal					
is.	LXamii	iei	33 Maxwell Lane	,			th Eas			Cecil					
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last	t birthday)	If Under	1 Year If	Under 24 Hrs. lours Min.	8. Date of Birth (Month, Day	9. Birl	hplace (State or	Foreign			
- A	Director		213–26–9603 ^{1XI M}	^{2□ F} 80	Yrs.	Months	Days H		06/01/1	929 Mar	yland				
	Du ≱ _		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Lo	cation					10d. Inside City	v Limits			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department if them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinal must be notified at ance.	ō	Maryland Cecil		orth 1						1 Tyes	•			
-		Director	10e. Street and Number	-11		10f. Zip	Code		1	Og. Citizen of What Co	ountry?				
1	Sa o	ai D	33 Maxwell Lane				21901			U.S.A.					
1	ms (y Funerai	11. Marital Status	Vas Decedent Ever in U.S. Armed Forces?	13. \	Was Deced	ent of Hispa	nic Origin? (Spe	crfy Yes or No-	14. Race - Ame Black, Whit					
99	or th		1 Never Married 2 Married 1 Ves Cive Vorce 1 Yes 2 No						Specify						
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212	r tha	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Ste	el Wo	rker			Steel Mill					
pu	at Hyg	Bec	17. Father's Name (First, Middle, Last)							Maiden Sumame)					
Maryland	Ment Ment arked atice	To	John Holland Steuern	agle, Sr.			I	Agnes Lo	retta W	illis	llis				
Aar Sab	raum		19a. Informant's Name/Relationship (Type, I			-				r, City or Town, State,					
e, e	Health Health Health ther t		David Steuernagle, S 20a. Method of Disposition			XWETT sition (Nam	Contract to the Contract of th	C. C. Commonwell	· · · · · · · · · · · · · · · · · · ·	aryland 21 20c. Location - City or					
Baltimore,	ages int of t: If it		1XXBurial 2 ☐ Cremation 3 ☐ Remo	val from State	etery, cren	natory or oti	her place)			Baltimore,		Бо			
	artme ortan injury	1	4 □Donation 5 □ Other (Specify) 21. Signature of Financial Service Licensee	Saci											
B	Depa fmpo any ir	-	1-30		1	407 O	Bruz Id Fas	zdzínski stern Av	. Funera Tenue. F	l Home, P. ssex, Mary	A. land 212	221			
4 1	-3		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one care	ons that caused the death. I	Do not ente	er the mode	of dying, si	uch as cardiac o	r respiratory arr	est,	Approximate Interval Betw)			
Р	hysician /Medical xaminer		Immediate Cause (Final disease or condition	COPD							Onset and D				
			resulting in death)	Due to (or as a consequen	ice of):										
	.xajiiiiei		Sequentially list conditions b.	CHF WI		SEV	ERE	AORTI	C STE	212043					
و سرد	nsit	nine	Sequentially that conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): PUMDNARY HYPERTENSIDN												
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3760, Q	institution death continuate be executed signed by the attending physicien and diedeched for use as the burial-transit	cail	d. =												
	ng ph as th														
So	tendir r use	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy						23d. Date of de						
P.O. Box 68	the at	sici	1 Vec 2 No	□Pregnant at time of death □Unknown		Other (spe				Month	Day Y	ear			
	ad by detac	by Physician/Med		iting to death but not resulting	na in the ur	nderlying ca	use given in	Part I	23e Did to	bacco use contribute to	the cause of de	eath?			
ds,	sign d be	d b	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COROHARY ARTERY DISEASE						100						
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2 2	e has age 2	Completed								y prior to med? death?	completion of ca	use of			
ita [certificete rector, pag	BeC	25. Was case referred to medical				26	. Place of Death		2 XNo 1 ☐ Yes	2 X No				
>	this ce al direc	ToE	examiner? 1 Yes 2 No Hospi	tal: 1 ☐ Inpatient 2 ☐ ER	/Outpatien	t 3 🗆 DO/	Othor	4 ☐ Nursing Hon		ence 6 Other (Spe	cify)				
0 2	Ster th		27. Manner of Death 28 1 XNatural 5 ☐ Pending	Ba. Date of Injury 28 (Month, Day Year)	b. Time of Injury	28	lc. Injury at Work?	2	28d. Describe h	ow injury occurred	njury occurred				
Space Spac															
N S	after Direction by	ertif	Signature determined determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							treet and Number or Rural Route Number, n, State)					
Div	within 24 hours after death. To the Funeral Director: After this certificete has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Physicie	n: To the best of my knowle	dge, death	occurred a	t the time.	fate and place, a	and due to the c	ause(s) and manner as	s stated.				
¥	n 24 ł he Fu olately	Medicai	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and the time, date and place, and due to the cause(s) and the time, date and place, and due to the cause(s) and the time, date and place, and due to the cause(s) and the time, date and place, and due to the cause(s) and the time, date and place, and due to the cause(s) and the time, date and place, and due to the cause(s) and the time, date and place, and due to the cause(s) and the time, date and place, and due to the cause(s) and the time, date and place, and due to the cause(s) and the time, date and place, and due to the cause(s) and the time, due to the cause(s) and the time, date and the time, due to the cause(s) and the time, due to the cause(s) and the time, due to the cause(s) and the time, due to the cause(s) and the time,								to the cause(s)				
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)	1		P.V. Naye D	MD			D006	5733		6/18/29					
1	01,		30. Name and address of person who comple												
7771	Sta	te.	126 A E • 1776H 31. Date filed (Month, Day, Year)	32. Registrar's Signature	LKT	, ,	MD	21921			-				
	Registr		JUN 1 9 2009	STREET 5 32. Registrar's Signature Leven 9.	park	la S									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) SCHNEIDER ILLIAN 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Anne Arundel Tate Hospice House Linthicum If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Year) 1 M 2 F Months Days Hours Min. June 20,1922 Maryland 213-14-5996 86 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Baltimore 10g, Citizen of What Country? 10e. Street and Number 10f, Zip Code 21225 USA 205 W. Arundel Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify: Specify: white 3Kl Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6th Cook A.A. Public School 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles F11oyd Lillie Ruth Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8305 Laico Ct. Pasadena Maryland 21122 <u>Gloria Jaschik</u> daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc 6/18/2009 Baltimore Maryland 21. Signal re of Funeral Service 22. Name and Address of Facility Stallings Funeral Home P.A. 3111 Mountain Road Pasadena Md 21122 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disa shock, of heart failur se, or complication that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to miniediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown

Physician /Medical Examiner

spital or Attending Physician: The law requires that the death certificate be executed ours after death.

eara Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Completed

Be

Certification: To

Medical

Division of Vital Records, P.O. Box 68760,

Physician

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Department of Health ar
Important: If item 27 is
any injury or other trau

and Mental

Director

by Funeral

Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner Physician/Medical

MICE

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed

26. Place of Death (Check only one)

1 ☐ Yes 2

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No

25. Was case referred to medical examiner? 1□Yes 2□No 27. Manner of Death

5 ☐ Pending investigation 6 □ Could not be

Hospital:

28a. Date of Injury (Month, Day,

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

23e. Did tobacco use contribute to the cause of death?

6 Other (Specify)

29a. Certifier (Check only one)

1 Natural 2 Accident

3 🗌 Suicide

4 Homicide

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of dertifie

29d. Date signed (Month, Day, Year)

derson who completed cause of death (Item 23a) (Type, Print) EYENSE HIGHWAY ANNAPOLIS MAZIYU 32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

within 24 hours a

To the Funeral C

completely filled Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For Amend #29c, per DVR G92 6/19/00 artificate of Death Reg. No. 3. Time of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day **Physician** 5:45 P M 2009 14 June Brenda Faye Sweeten /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death **Examiner** Washington Golden Living Center Hager stown
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours Days 1 □ M 2 👿 F Yrs 312-54-8995 60 Indiana Director 5/30/1948 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 ▼No Director Washington MD Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If firen 27 is marked other than "natural" ~ *** any Injury or other traumatic event. U.S.A. 206 South Fork Drive 21740 Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🔀 No Specify: White 2 3 ☐ Widowed 4 X Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Recreation Vehicles 12 Sewer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clyde Brenneman Catherine Bridenstien ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Beverly Kipe/ Friend 1027 Potomac Avenue, Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry 6/16/2009 | Hanover, Maryland 4 XDonation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service License 7522 Connelley Dr., Ste.P, Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Circhosis ivel **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of) physician Physician/Medical IE EEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Day Year jo in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) signed by the ald be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 WUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2 🗓 No 1∐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 🗌 Inpatient 2 this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 28c. Injury at Work? After 5 ☐ Pending investigation Injury 1 X Natural 1 □ Yes 2 □ No after death 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier **Medical** (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Division or Vital Records, P.O. Box 68760. To the Hospital or Attending Physician: within 24 hours a

> 368 MILL STREET , Hagerstown, MD, 21740 Andaleeb Alli 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D66116

MD

6/15/05

YdIA 09-04633

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. UNK UNK State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ June 10, 2009 1802 hrs Medical Examiner 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4003 Biddison Lane Baltimore 7. Age (In yrs. last birthday) Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Davs Hours Director Country) М 2 VF Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1 V Yes 2 No 28a-f show Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21206 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 V Never Married Yes Pages 1 and 2 should be filed within 72 hours after If Yes. Give Yeer Yes 2 V No specify: Specify: Widowed 4 Divorced <u>۾</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) narked other than 'event, the Medical Baltimore, MD 21215-0036 2 Department of Health and Mental Hygiene. Important: If item 27 is marked other th injury or other traumatic event, the Medi 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname Be UNKNOWN 19a. Informant's Name/Relationship (Type, Print (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) V Burial 2 Cremation 3 Removal from State -2009 MOEN Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 8800 HAMORD ROAD 1981 - CREMATION 23a. Part | Eliter the insease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Physician Between Onset and /Medical a. Sharp Force Injuries Immediate Cause (Final disease Ęxaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed Physician/Medical the attending physician and for use as the burial -UNPENDED **AMENDED** Box 68760. IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 23d. Date of deliven Live birth 3 Ectopic pregnancy Month Dav Year Fetal death past 12 months? Other (Specify) 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions Records, P.O. 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 ✔ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available autopsy performed? prior to completion of cause of has t death? certificate ✓ Yes 2 1 V Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, t 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Other Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 ✓ Other: Scene 1 V Yes 28a. Date of Injury FOUND: 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Subject assaulted FOUND Natural Yes 2 V No Pending Jun 10, 2009 1750 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 4003 Biddison Lane, Baltimore, MD determined 4 V Homicide (Specify) Townhouse / Rowhouse Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) June 11, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month William Theodore Samuelson 2009 Juno 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Dea uare 8. Date of Birth (Month, Day, Year) Jan. 19, 1922 Security Number Birthplace (State or Foreign Country) Age (In vrs. last birthday) Min 389-14-4850 1 XM 2 ☐ F Months Days Hours 87 Wisconsin Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Parkville 1 ☐ Yes 2 XNo Baltimore 10e Street and Number 10f, Zip Code 10g. Citizen of What Country? 21234 8820 Walther Blvd. Apt. 4121 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 TYYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify White Specify: 3 ☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Auro Parts (Murray) Elementary/Secondary (0-12) College (1-4or 5+) Vice President 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marvin Samuelson Margaret Ryan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 82 Woodview Drive-Fawn Grove, PA 17321 Mary Samuelson-daughter Place of Disposition (Name of cometers, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery June 20,2009 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8800 Harford Road EVANS FUNERAL CHAPEL AND CREMATION SERVICES Parkville,MD 21234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neumonio Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dronic Due to (or as a consequence of) ement Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4⊒Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 Hunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 TYes 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred

The law requires that the death certificate be executed buriai-trar Division or Vital Records, P.O. Box 68760, attending physician as the nse for detached the signed by been : this certificate has or Attending Physician: fur-eral director, Afler

Examiner Certification: To

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Funeral

Director

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r than "natural", or items 23a or the Medical Examiner must be

snould be file th and Mental Hve 7 Is marks or other traumatic event,

permit. Pages 1 and 2 Department of Health ar Important: If item 27 Is any Injury or other trau

Physician

/Medical

Examiner

Pages 1 and 2 should

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Mary

Baltimore,

Director

Funeral

Be Completed by

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MD

25.		case	referred	to	medic
	exam	iner?			

27. Manner of Death 1 Natural 2 Accident

3 Suicide 4 Homicide

(Check only one)

29a. Certifier

28a. Date of Injury (Month, Day Year) 5 Pending investigation

6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined

28b. Time of

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 🖅 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

License number

29d. Date signed (Month, Day, Year)

of death (Item 23a) (Type

Franklin Square Drive Baltimor 31. Date filed (Month, Day, Year)

Registrar

within 24 hours at er death To the Funeral Director: filled by the

Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death June 12, **Physician** Marian Adelaide Stahelek 2009 9:10 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford 702 Country Village Drive Apt. 2C Bel Air If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 12, 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 213-28-2354 78 ີ່ 1930 **Director** Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f show Director 1 ☐Yes 2 X No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 702 Country Village Drive Apt. 2C 21014 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, Ile Medical Examinations. Black, White, etc 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify 2 Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Dept. of the Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anthony Estes Silveira Georgia Irene Beck 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne Renjel / Daughter 2039 Colgate Circle Forest Hill, MD 21050 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Evans Funeral Chapel Bel Air 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State June 15, 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 2009 21. Signatur Evans Funeral Chapl & Cremation Service-BelAir 3 Newport Drive Forest Hill, MAryland 21050 23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only on ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) law requires that the death certificate be executed burial-tra Due to (or as a consequence of) Box 68760, Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑No Dav Year 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown signed by the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ cate has been signated page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate performed 2 240 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: 7 24 hours after death. Funeral Director: After this certifica director 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 □Yes 2 □No filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical The desired in the desired results of my knowledge, death occurred at the time, date and place, and due to the cades(s) and manner stated.

2 ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29b. Signature and title of cortific 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

PHTSZUZAN

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PHECIPILIVATPUMER

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Catherine A. Schaefer June 2009 1620 hrs 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death St. Agnes Hospital N/A Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Months Days Hours Min 1 M 2 X 1070771915 216-16-9993 93 Baltimore, MD Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Baltimore Catonsville 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 719 Maiden Choice Lane HR333 21228 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐Yes 2 🛛 No Specify. 2 ¾ Widowed 4 □ Divorced Completed 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accountant State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Vito Minnie Suttolota ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Michael Castino (Cousin) 13 Bellfalls Way, Baltimore, Maryland 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 06/23/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part. Enter the disease, or com(li ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Ci Due to (or as a consequence of): Sequentially list conditions, if any least 11 cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Due to (or as a consequence of) Physician/Medical IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No 1 □Yes 2 🗔 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1□Yes 2□No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1_Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 🗆 No 2 Accident

Box 68760, P.0. Division of Vital Records,

that the death certificate be execu burial-trail attending physician the as use ģ signed I peen page 2 s certificate After To the Hospital or Attending death. ours after death.

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filled in by the fi within 24 hours a

Physician

/Medical

Examiner

Funeral

Director

show

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "Modical Examinar must be notified at

within 72 hours after death with

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Pages permit. Pages Department of Important: If its any injury or o

Physician /Medical

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Certification: To

Medical

3 ☐ Suicide

29a, Certifier

4 \ Homicide

(Check only one)

30. Name and addre

29b. Signature and title of certifier

Baltimore, Maryland 21215-0036

State Registrar

1051K Any Whaids (hoip Registrar's Signature 31. Date filed (Month, Day, Year)

6 Could not be

determined

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🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

JUNE 18, 2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

of person who completed cause of death (Item 23a) (Type, Print)

ND

09-04	759	
John	Alfred	Scott

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		- For State Certificate of Death	Reg.	
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Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yes Months Da		1963 Foreign Country) PA
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r death with the Maryland or items 23a or 28a-f show any must be notified at once	Funeral Director	10e. Street and Number 742 Nottingham Drive 2	1001	USA
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D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	BeC	Warren B Scott Ir		
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Baltimor permit. Pages Department of Important: If	1	4 Donation 5 Other Specify: Other Specify: 22. Name and Addr	ess of Farlity Qualon (delistown MD 21133
Balt permit. Depart Import injury		Vaugh C. D 87281	iberty Robbi fai	ndalistown MD 21133 st. shock, or heart Approximate Interval
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Divisi Divisi To the Hospital or Att within 24 hours after de To the Funeral Direct completely filled in by		20a Certifier	e, date and place, and due to the causinion, death occurred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
To the Hos within 24 h To the Fur	Medical	29b. Signature and title of certifier 29c. Li	cense number	29d. Date signed (Month, Day, Year)
	-		o.C.M.E.	June 16, 2009
		30. Name and address of person who completed cause of death (Item 23a)		
Q		Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimo	ore, MD 21201	
S	tate	31. Date filed (Month, Day Year) 32. Registrar & Signature		

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State of Maryland / Department of Health and Mental Hygien
Cartificate of Death

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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		12	}	0							(First Middle)	o Maid	en Surname)		
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shou and and 7 is nation	-		Marlene Hurt/aunt 6759 Fasque Lane Hayes, VA 23072 20b. Place of Disposition (Name of cemetery, Date 20c. Location - Cit								ity or Town	State			
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Baltimo permit. Page Department of Important: injury or oth		21. Signature of Funeral Service ROTIAL d.	S We	ide, Din	rector		Anato	my B	oard	655	oWr Ba	lti	more St	reet	
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	letel		Examiner:	On the basis of	examination	and/or inv	estigation, i	n my opi	nion, deat	h occurre	ed at the time	e, date a			
To the first	comp)		and manner sta	ited				cense num				29d. Date sig	ned (Monti	h, Day, Year)
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		ques													
	30. Name and address of person who completed cause of death (Item 23a) And Rubin MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201														
		Ana Rubio MD.	Assistan	nt Medical E	xaminer	111 P	enn Stree	et, Bai	umore,	1VID 2 1					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Of IV		artment of Health an tificate of Death		Reg. No. 2 () ()	19760	
Phy	ysicia	an	Decedent's Name (First, Middle, Last)	7.5	irain	2. Date of Dea Month	Day Year	3. Time of Death	
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Fund Direc				ge (In yrs. last birthday) 60 Yrs.	If Under 1 Year If Under 24	Min. (Month, Day	9. Bir (, Year) Co	thplace (State or Foreign untry) MD	
and			Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits	
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or 28	e noti	Director	10e. Street and Number		10f. Zip-Code		10g. Citizen of What Co	untry?	
ath w	netb		1907 E. 30th Street	Suprin HC 142 1	21218	2 (Specify Vac or No	U S A	rican Indian	
036 urs after de al", or item	xaminer n	by Fu	11. Marital Status 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Deceden 1 ☐ Yes 2 ₹ If Yes, Give Year or Dates:	No I	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P	uerto Rican, etc.)	Black, Whit		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show	e Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or	(Give life, L	dent's Usual Occupation kind of work done during most of DO NOT use retired) STRUCTION	f working	16b. Kind of Business	^{/Industry} Unk	
d 2 filed v Hygie	ř,		9th grade N/ 17. Father's Name (First, Middle, Last)	AI	18. Mother's	Name (First, Middle,	Maiden Surneme)		
land be fental	ic eve	To Be	Ernest Monroe Torain		Bena	Jennings	3		
Pary 2 shou and N is ma	anmat		19a. Informant's Name/Relationship (Type. Print)		ng Address (Street and Number			6	
e, North and Health	her tr		Marlene Lemons-Siste 20a. Method of Disposition	20b. Place of Dispo	Rolling Road	Date	sville, M		
timor t. Pages tment of I	Jury or o			King M	emorial Pk 6	-20-2009	Randall	stown, MD	
Bal permi Depal impo	any ir		21. Signature of Pulleral Service Deensee		1101 E. Nor		East F/H Balto,	MD 21202	
			23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	d the death. Do not ent				Approximate Interval Between	
Physici	ian	ì	•		ary hypert	ension		Onset and Death	
/Medi	_		resulting in death) Due to (or a	e pulmon s a consequence of):	2 31				
	_	ē	Sequentially list conditions, b. 505	s a nonsecuence off					
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	ansit	Examiner	cause (Disease or injury that initiated events	mary e	mbolisy				
an and			resulting in death) Last Due to (or a	s a consequence of):					
68760, tificate be executed g physician and	the bu	dica	d						
K 68 sertific	nse as	/Me	IF FEMALE: 23c. If yes, outcom	e of pregnancy			23d Date of de	liven	
I Records, P.O. Box 6 The law requires that the death certile has been signed by the attending	ched for u	Physician/Medical	in the past 12 months?	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year		
dS, P.	d be deta	۵	Part II. Other significant conditions contributing to death	but not resulting in the u	underlying cause given in Part I.	23e. Did to	obacco use contribute t	.	
COTO v requi	shouk	Completed				24a. Was a	an 24b. Were a	utopsy findings available	
The law	age 2	ошо					sy prior to med? death? 2 \(\sum \text{No} \) 1 \(\sum \text{Yes}		
	ctor, p	BeC	25. Was case referred to medical examiner?			Death (Check only or			
Of V Physic	funeral director, page	၉	1 ☐ Yes 2 No Prospital: 1 Ninpa				lence 6 Other (Spe	cify)	
On ding P. After t	funeri	ţi	27. Manner of Death 1 ★Natural 5 □ Pending 2 □ Accident investigation 28a. Date of In (Month, D	iury 28b. Time o ay Year) Injury	f 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		now injury occurred		
Division of Vital Records, or Attending Physician: The law requires the after death. Director: After this certificate has been signe.	in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of in	njury - At home, farm, str etc. <i>(Specify)</i>			Street end Number or F n, State)	tural Route Number,	
Hospital 24 hours Funeral	completely filled	edical Ce	29a. Certifier (check only one) 1 ★Certifying Physician: To the besis and manner: and manner:	of examination and/or in					
To the within 7	compl	Mec	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mon	th, Day, Year)	
	_		13. Jaharelani	dM	res-000		June 11	1,2009	
д	1	1	30. Name and address of person who completed cause o	7-1-1	Print)	00 N - 41 M		,	
V	Sta	20	Rabak Tabatabay 31. Date filed (Month, Day, Year) 32. Begist	rar's Signature		UU NORTH WO	iie St, Baltim	ore, MD, 21287	
Re	gistra	U	4 0 0000	mar's signature	arked				

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nnie Turner		Please Type or Print in Black Indelible Ink. Ensure All Copie		ibie.	
nine rumei		State of Maryland / Department of Health and Mental Hy 1-For State Registrar Certificate of Death		2009	1976
Physicia edical Exami		Decedent's Name (First, Middle,Last)	2. Date of Death Month June 16, 20	Day Year	3. Time of Death 1255 hrs
-		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1121 Washington Boulevard Baltimore	ounc 10, 2	4c. County of Death	
Funeral Director		5. Social Security Number 2 16-62-0407 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min.	-	MM/DD/YYYY) 9. Birth Foreign Cou	
<i>н</i> апу		Usual Residence of Decedent 10a. State			10d. Inside City Limits
uryland Sa-f shov at once	Director	MD N/A Baltimore 10e. Street and Number 10f. Zip Code	10	g. Citizen of What Coun	1 X Yes 2 No
th the Ma 23a or 28 notified		1121 Washington Blvd. 21230	asif Van an Na	USA	en Indian Block
fter death with the Maryland I", or items 23a or 28a-f show any ter must be notified at once.	y Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes 2X No 1 Yes, specify Cuban, Mexican, Puerto		14. Race - Americ White, etc. Specify:	white
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Montal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) Office Worker	vork done red)	16b. Kind of Business/Ir Sun Pa	•
5-00(led withing the spice of the Mec	Com	17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, M	aiden Surname)	
121 be fi ental wrked	Be		argie N		
MD 2. 12 should th and M 127 is m umatic e	T ₀	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F Paul T. Darmafall / Nephew 213 Orchard Avenue		oklyn Park	MD 21225
ges l and tt of Heal		20a. Method of Disposition 1 Burial 2 XX remation 3 Removal from State Ardent Crematory 6/	Date 17/09	20c. Location - City or	Town, State Maryland
Saltim ermit. Pa epartmen mportant ijury or		21. Signature of Funeral Script Licensee Victor P. Dod 22. Name and Address of Facility Charles L. Steven 1501 East Fort			_
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o	Avenue r respiratory arre	Baltimo st, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			Death
	<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
-	Examiner	Course Course or injury that initiated events resulting in death) Last Due to (or as a consequence of):		iv.	
e executed cian and rial - transit		d			_
O, e be e. ysician burial	edic			Loga Data of delivers	
Division of Vital Records, P.O. Box 68760, within 24 hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	ysician/Medical	FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant 4 Pregnant at time of death 5 Other (Specify) 9 Unknown 9 Unknown	incy	23d. Date of delivery Month	ay Year
P.O. Es that the gned by the edetached	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus	23e. Did tot	pacco use contribute to	
tal Records, P.O. Ecian: The law requires that the decrificate has been signed by the ector, page 2 should be detached	Completed	Diabetes memus	24a. Was a autops perforr	n 24b. Were au	copsy findings available completion of cause of
Re The		25. Was case referred to medical 26.Place of Death (Check		No 1 Ye	s 2 No
/ital sician is cert lirecto	Be	examiner? Hospital: Insertion 3 ED/Outpetion 3 DOA Other; Nursing		Residence 6 V Other	Scene
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	on: To	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?		ow injury occurred	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.		treet and Number or Ru	ral Route Number, City
Divospital ospital ouneral Divided ily filled i		4 Homicide determined (Specify)	or Town, St		
To the Hospital within 24 hours: To the Funeral completely filled	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.		and place, and due to the	e cause(s)
	Ž	29b. Signature and title of certifier 29c. License number O.C.M.E.		29d. Date signed (Mor June 17, 2009	nth, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) Zahiullah Ali, M.D. Assistant Medical Evaminer, 111 Penn Street, Baltimore, MD 21	201		
	tate	HIRE A M 7 HIRE 1 / 27 A M 7 1 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	201		<u> </u>
Regis	trar		- OCHE		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** A last birthday) If Under Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreigr Country) Age (In yrs. **Funeral** 215-28-09 Months Days Min. 1 M 2 □ F Hours Г **Director** m Usual Residence of Decedent 10a. State 10c. City, Town or Location 28a-f shov ? is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo 力 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 Married Yes 2 Yes, Give 2 No 1 Never Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ If Yes, Give Year or Dates: AMU 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event Elementary/Sec ndary (0-12) College (1-4or 5+) Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2101 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evans Funeral Cha 21. Signature of Funeral Service Licensee 22. Name and Address el-Bel Air Newborti Forest)Y v 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CARCINOMA OF THE STOMACH 8 MOS. disease or condition resulting in death) / /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Exami Due to (or as a consequence of): attending physician a for use as the burial-Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) Ö as been signed by the 2 should be detached 1 □ Yes 2 No 9 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by Hypertension 1 🔯 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2X No Dehydration 24a. Was an has autopsy page, certificate Vital 1 ∐Yes 2XXX funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5\(\text{P Residence} \) 6 \(\text{Other} \) Other (Specify) Medical Certification: To 1 ☐ Yes 2 No of 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 🕅 Natural 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A investigation 1 □Yes 2 □No 2 Accident the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. 29b. Signature and title of certifle 29c. License number 29d. Date signed (Month, Day, Year) June 18, 2009 M.D. D0017728 Q. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21236 8022 Belair Rd. Balto., MD M.D. Yin Oung, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Due to for as a consequence off

Due to (or as a consequence of)

If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day, Year)

2009

signed by the attendir the detached for use ficate has been siç 7, page 2 should b

Physician/Medical þ Completed Be ၉

Examine certificate be executed the attending physician and the for use as the burial-transit

Records, P.O. Box 68760,

After this certificate has funeral director,

Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

Certification: filled in by the

5 Pending investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29b. Signature and title of contified 30. Name and # dress of person

25. Was case referred to medical examiner?

1 Tes

27. Manner of Death

1 X Natural

2 No

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 No

IF FEMALE

who completed cause of death (Item 23a) (Type, Print)

Hospital:

29c. License number

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

3 Ectopic pregnancy

5 ☐ Other (specify)

29d. Date signed (Month, Day, Year)

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

2 🗌 No

1 🗌 Yes

autopsy performed? Yes 2

Other: 4 \square Nursing Home 5 \square Residence 6 \blacksquare Other (Specify) HOSPICE

28d. Describe how injury occurred

24a. Was an

1 ☐ Yes

26. Place of Death (Check only one)

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No

3 Probably 4 🗆 Unknown

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2300 DULANEY VALLEY RD. JACKIE JONES, CRNP TIMONIUM, MD 21093

Registrar

State

JUN 19 2009

DHMH 17 Rev 1/2001

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			For State Registrar	State of N	Marylan		artmer rtificat			and M		Reg. No.	2009	1976	ş.
	Physici /Medio		1. Decedent's Name (First, Middle, L Ray F. Wilkie	.ast)							2. Date of De Month June	path 15	2009	3. Time of Death 10:30 A. N	1
	Examin		4a. Facility Name (If not institution, g Stella Maris H				4b. City,		Location o	of Death	4c. County of Death Paltimore County				
	Funeral Director					last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month D	1920	thplace (State or Foreign ountry) Sas	חו	
	f show	or	Usual Residence of Decedent 10a. State 10b. County Maryland Harfo	and County		ty, Town or Lo								10d. Inside City Limit	
	with the N 3a or 28a-	I Director	10e. Street and Number 105 C Sunshine	e Court			10f. Zip Code 21050					10g. Citizen of What Country? United States			
а.ш.	in 72 hours after death with the Maryland n"natural", or items 23a or 28a-f show ledical Examirer must be rollited at	by Funeral	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Ayes 2 If Yes, Give Year or Date:	s? ⊒No		Was Dece If Yes, spe		ispanic Ori in, Mexicar Specify:		ecify Yes or No Rican, etc.)	0-	14. Race - Am Black, Whit Specify: Wh	te, etc.	
, 2009 10:30 a.m. Maryland 21215-0036	n 72 ""nai	Completed	15. Decedent's (Specify only highest g	Education (rade completed) College (1-40)	ed) (Give i			dent's Usual Occupation kind of work done during most of work DO NOT use retired) OCIVE TEST Engineer			ing	I		Business/Industry	
09 I land 2	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Inc. Monce.	To Be C	17. Father's Name (First, Middle, La Horace Wilkie	st)		1			18. Mother		(First, Middle ker	, Maiden	Surname)		
	und 2 sho alth and I 27 is ma er trauma		19a. Informant's Name/Relationship Mrs. Margaret		life)	1 0 5™€		ine c	OUL C	er or Rura Forces	al Route Numb	Mary L	and 21050	Zip Code)	
JUNE 15. Baltimore,	Pages 1 annent of He ant: If item ury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special Control of Control		te Eva	Place of Dispo cemetery, crei Ins Fune	sition (National Original Control Cont	me of other place apel	e) [م او	Date 1/69		t Hill, M		
JUNE	permit. Departimporta any inju		21. Signature of Funeral Service Lic	ensee		E ²	2. Name a Vans F Newpo	nd Addres Unera rt Dr	ive, F	el & brest	Cremetic Hill, M	n Ser aryla	vices — E nd 21050	el Air	
	Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition	ly one cause on each	sed the deat line.		ter the mod	de of dyin	g, such as	cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	-	as a consec										
.lo.	cuted Id ansit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Friends deriving Cause (Disease or injury that initiated events	Due to (or:	as a consec	quence of):									
8760,	eath certificate be executed attending physician and for use as the burial-transit		resulting in death) Last		Due to (or as a consequence of):										
WILKIE s, P.O. Box 6	the death certifica y the attending phoched for use as the	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)									23d. Date of d Month	elivery Day Year	
Y WIL ds, P.	w requires that the de been signed by the should be detached	ρ	Part il. Other significant conditions	contributing to death	n but not res	sulting in the u	ınderlying	cause give	en in Part I					to the cause of death? Probably 4 ☐ Unknow	vn
RAY W Division of Vital Records,	i: The law req icate has beer ; page 2 shou	Completed									perl 1 □ Yes	opsy formed? 2 X No	prior to death?		le f
Vit	siclar s certif	Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	Hospital:	ationt 2] ER/Outpatie	at 3 🗆 D	OA Oth			h (Check only		6 V 1Other (Se	ecify) HOSPICE	
יס	ig Phy ter this neral d	n: To	27. Manner of Death	28a. Date of I (Month,		28b. Time of		28c. Injur Worl			28d. Describe			HOSPICE	
)ivision	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification: To	1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of		ome, farm, st	M 1 □ Yes 2 □ No eet, factory, office 28f. Location (Street and Number or Rural City or Town, State)			Rural Route Number,					
u	ne Hospital 124 hours : le Funeral letely filled	Medical Ce		Physician: To the be aminer: On the basi	s of examin										
	To th withir To th comp	Me	29b. Signature and Ale of certifier	LANT	7		29	c. Licens	e number	2		29d. Da	ite signed (Moi	nth, Day, Year)	
	C/		30. Name and address of person what JACKIE JONES, C	RNP 2300	DULAN	EY AVAL		D.	TIMON	NIUM,	, MD 21	093			
	Sta		31. Date filed (Month, Day Yay)	9 Character	etrar's sign	ature									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Maryland	/ Department Certificate		Mental Hygien	2003	19765	
	Physic /Med		1. Decedent's Name (First, Middle, Last)	501	Winder		2. Date of Death		3. Time of Death 2: 25 AM	
	Exami	ner	4a. Facility Name (If not institution, give	Hospital	4b. City, To	own, or Location of Deat	h 4	c. County of Death		
	Funeral Director		5. Social Security Number 6. Security Number 6. Security Number 10	7. Age (In yrs. las	t birthday) If Under 1 Months Months	Year If Under 24 Hrs Days Hours Min.	(Month Day Yea	9. Birthplac Country	ce (State or Foreign	
	Ra-f ehow	ctor	10a. State 10b. County	10c. City, 1	Town or Location Baltimo	ire.		10d	. Inside City Limits 1 No 2 □ No	
	s 23a or 2 oust be no	Funeral Director	10e. Street and Number 408 Woodhaue			21216		Citizen of What Country	?	
9800	be filed within 72 hours after deeth with the Marylend nat Hygiene. od other than "natural", or Items 23a or 28a-f show event, the Medical Examinar must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 ▼No If Yes, Give Year or Dates:	13. Was Deceder If Yes, specification of the second of the	nt of Hispanic Origin? (Sy Cuban, Mexican, Puerl	pecify Yes or No- to Rican, etc.)	Black, White, etc	14. Race - American Indian, Black, White, etc. Specify: Black	
2121	filed within 72 I Hygiene. Ither than "nat ent, the Medica	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		life. DO NOT use	done during most of wor	rking	Kind of Business/Indus		
Maryland	should be fill ind Mental Hy marked oth umatic event	To Be	17. Father's Name (First, Middle, Last) JOSEPN PevSOV 19a. Informant's Name/Relationship (Ty)	, Sr.		Minni	ne (First, Middle, Maide	S		
	1 and 2 s Heelth ar em 27 le thar trau		Samuel L. Winder 20a. Method of Disposition	er, III/Son	3 Deliant Solution (Name of Disposition (Name	n Lane	Bear DE	= 19701		
Baltimore,	it. Page rtment o rtant: If njury or		1 Burial 2 □ Cremation 3 □ Ro 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	emoval from State AVB	othery, crematory or other outus Cenn	etery 06	1	ocation - City or Town Utimore Receipe 54.00	, MD	
8	Deper Deper Impo		23a. Part I. Enter(the) disease, or complice shock, or hear failure. List only on	ations that caused the death. I	8728	Liberty Re	ad Randal	Ustown MD		
	Physician /Medical Examiner		shock, or hear failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequen-	lung Ca	ncer		l <u>n</u> i	terval Between nset and Death	
68760,	ficate be executed physicien and strengt the burial-trangt	dical Examiner	Sequentially list conditions, a.y. back you introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d. d.	Due to (or as a consequent						
	ath certi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 □Ectopic pregr			23d. Date of delivery Month Da	y Year	
Records, P	w requires that the de-	þ	Part II. Other significant conditions cont	ributing to death but not resulting	g in the underlying caus	e given in Part I.	23e. Did tobacco	use contribute to the c	ause of death?	
C	the h	e Completed	25. Was case referred to medical				24a. Was an autopsy performed?	24b. Were autopsy prior to comple death?	findings available etion of cause of	
>	nysicia his cert I directi	To B	examiner?	spital: 1 XInpatient 2 ☐ ER/6	Outpatient 3 DOA	04	th Check only one ome 5 Residence	6 Other (Specific)		
Division of Vital	within 24 hours after death. To the Funeral Director: After this certifice completely filled in by the funeral director, is		27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation 3 □ Suicide 6 □ Could not be	28a. Date of Injury (Month, Day Year)	o. Time of Injury M	Injury al Work?	28d. Describe how inju			
	ours after death. eral Director: A	Certifi	4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)			28f. Location (Street ar City or Town, State	9)		
1 1	n 24 ho	edicai	29a. Certifier (Cneck only one) 1 X Certifying Physic 2 Medical Examine	r: On the basis of examination a and manner stated.	and/or investigation, in	ne time, date and place, my opinion, death occur	and due to the cause(s) red at the time, date and) and manner as stated d place, and due to the	I. cause(s)	
To t	withiw To th		29b. Signature and title of certifier	1. 1 .		cense number		te signed (Month, Day	, Year)	
	10		30. Name and address of person who com	Mica 1) Octor		ES-000		ne 17,20	909	
	12		Brian Houston, J	ohns Hopkins	Hospital 60	30 North W	Jolfe Street	Baltimore.	MD 21287	
	Stat Registra	_	31. Date filed (Month, Day, Year) JUN 1 9 2009	32 Registrar's Signature	barre					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene

2009 19766

nald Allan Wilgi		State of Maryland / Defor State	epartment of Certificate of	Death		Reg. No.		
/ Develoing	Reg	gistrar Decedent's Name (First, Middle,Last)	OUT CONTROLLE		2. Date of Dea Month	Day	Year	3. Time of Death 0850 hrs
ysician ec xamine	er e	Ronald A. Wilgis			June 1, 2	009	County of De	 eath
	4a	. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of E Baltimore	Death			
		3211 Guilford Avenue, Apartment 1	yrs. last birthday)	If Under 1 Year If Under 2	24Hrs. 8. Date of E	irth(MM/I	DD/YYYY) g.	Birthplace (State or Foreign
Funeral	5.	Social Security Hamber UTIA		Months Days Hours	Min. Dec .	15. 1	938	Country) UTTK
Director			Yrs		Dec .		330 1	
8:		sual Residence of Decedent Da. State 10b. County 10c	c. City, Town or Locat	ion				10d. Inside City Limits 1 Yes 2 No
OW BIL	_ ``	MD	Baltimor	·e				
yłand n-f sh	힐	0e. Street and Number		10f. Zip Code		10g. Citi:	zen of What	Country?
th the Maryland 23a or 28a-f show any notified at once.	Director	3211 Guilford Avenue #1		21218			USA	merican Indian, Black,
vith th		1. Marital Status 12. Was Decedent Eve	16.5	as Decedent of Hispanic Origin Yes, specify Cuban, Mexican,	n? (Specify Yes or ' Puerto Rican, etc.)	No-	14. Race - A White, e	
eath v item ust b	Funeral	1 Never Married 2 X Married 1 Yes 2	unki	Yes 2 X No specify:			Specify:	white
ifter d	교	3 Widowed 4 Divorced If Yes, Give Year	h lass Breeds	ent's House Occupation (Give k	ind of work done	16b.	Kind of Busin	ness/Industry
ours a atura xamii	ᇵ	15. Decedent's Education (Specify only highest grade complete Secondary (0-12) College (1-4 or 5+)	during r	most of working life. DO NOT L	use retired) unl	٥		un
6 172 h	et let	Lightentalyrestation						
5-0036 iled within 7 Hygiene. 1 other than the Medica		unk 17. Father's Name (First, Middle, Last)		unk 18.Mother's	s Name (First, Midd	e, Maider	n Surname)	unk
filed al Hyged of	ادہ	77.100.0			D. al Deute	Number	City or Town	State, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Num			21201	
AD 2 sho 27 is 1 mati		O.C.M.E.		Penn Street F osition (Name of cemetery,	Date	MD 20c	Location - C	City or Town, State
e, e, l and l Healt		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	4	other place)				
Pages ent of		4 Donation 5 Nother Specify: in state		. Name and Address of Facility	,			
alti.	ı	October of Euperal Service Licensee	ector S	tate Anatomy I	, 30ard, 655	W. F	3altim	ore Street
B F G H E		23a, Part I. Enter the disease, or complications that caused the	he death. Do not ente	altimore, MD er the mode of dying, such as c	ardiac or respirator	y arrest, s	hock, or hear	rt Approximate Inter Between Onset a
sician Medical	- 1							Death
Examiner	ı	Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Condition resulting in death)	guence of):	7136430				
		b.						
	je.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence)	quence of):					
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a conse	quence of):					
ited d ansit		events resulting in death) Last d d						
iO, e be executed ysician and burial - transit	edical	UNPENDED AMENDED					23d. Date of	delivery
60, ate be e thysicia	Med	IF FEMALE: 23c. If yes, outcom	ne of pregnancy	Fotol dooth 3 Fotor	nic pregnancy		Month	Day Year
587 ertifica ding p	lan/	23b. Was decedent pregnant in the past 12 months?	time of death 5	Fetal death 3Ector Other (Specify)		_		
Box 6876 c death certificate the attending phy ed for use as the l	Physician/M	1 Yes 2 No 9 Unknown g Unknown					use conti	ribute to the cause of death?
	F G	Part II. Other significant conditions contributing to death	n but not resulting in t	the underlying cause given in I	Part I. 23e.	Uld tobac	2 No 3	Probably 4 Unknow
P.O.	b y					. Was an	24h	Were autonsy findings avail
ds, equire	Completed					autopsy		prior to completion of cause death?
COF law r has b	1 5				1 🗸	Yes 2		1 Yes 2 N
Re The	ြိ				th (Check only one)	-		✓ Other: Scene
Division of Vital Records, To the Hospital or Attending Physician: The law requiring within 24 hours after death To the Fineral Director: After this certificate has been shown in the Fineral willed in by the fineral director, page 2 should it	o Be	examiner? Hospital: 1 Inpatie	ent 2 ER/Outpa				w injury occur	
of V g Phy fter th	يّ ا	27 Manner of Death 28a. Date of Inj	ury 28b. Tim Year)	e of Injury 28c. Injury at W		SCHOOL NO.	W Hijary occur	.,
OD (endin ath or: A	Certification:	1 ✓ Natural 5 Pending 2 Accident Investigation				ation (Str	reet and Num	iber or Rural Route Number
ViSion Att	fica	2 Accident investigation 28e. Place of I	njury - At home, farm	, street, factory, office building	or or	Fown, Sta	te)	
Divalours af	Į,	4 Homicide determined (Specify)		to the time date and	Injace and due to t	ne cause	(s) and mann	er as stated.
Hosp 24 ho Func			ny knowledge, death amination and/or inve	occurred at the time, date and estigation, in my opinion, death	occurred at the tim	e, date ar	nd place, and	I due to the cause(s)
To the	Medical	and mainer states	1	29c. License num	ber		29d. Date siç	gned (Month, Day, Year)
	2	29b. Signature and title of certifier		O.C.M.E.			June 2, 2	.009
		unes 2	Lasth (Ham 22a)					
		30. Name and address of person who completed cause of Ana Rubio MD. Assistant Medical Exa	iminer 111 Pe	enn Street, Baltimore, N	MD 21201			
		32 Regist	i O'construct	A				
Reg	Stat	e ST. Date lied (MORRIS DATE O 2000	m B. x	parle			OCA	AF.
1.00	-						UUII	# 6 Nov

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		1	For State Registrar		State	of Marylar			of Health a of Death	and Me	_	giene, Reg. No.	2009	19	767
Div			1. Decedent's Name	(First, Middle	, Last)					2	. Date of De		Year	3. Time	of Death
	sicia edic		Edwin Li	onel Y	ohn						ine	18,	2009	3:15	P M
Exa	mine		^{4a.} Facility Name <i>(If</i> Golden Li		, give street and r	number)		**	vn, or Location o tminste1				County of Dea ${ m carroll}$	th	
Fune	ral		5. Social Security Nu		6. Sex	7. Age (Ip yrs.	last birthday)	If Under 1	ear If Under	24 Hrs. I a	. Date of Bir	Birth 9. Birthplace (State			e or Foreign
Direc			215-42-52	58	1 ¥ ∑ M 2□ F	66	Yrs.	Months D	ays Hours	Min.	R 22,	1943	3	MD	
and	20	-	Usual Residence of 10a. State	Decedent 10b. County		10c. Ci	ity, Town or Lo	cation						10d. Inside	City Limits
Maryl -f sho	Ded a	ģ		Carrol	1	West	minste	r						1 □Ye	s 2≝No
th the	DOUG)irec	10e. Street and Nun	nber				10f. Zip Co	ode	_		10g. Citiz	en of What Co	ountry?	
ath wi	9	la La	1716 Bloo	m Rd.				2115				United States			
DESIGNOTE, IMARYIBING 21213-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show	Samer	by Funeral Director	11. Marital Status1 ☐ Never Marrie3 ☐ Widowed		Armed	s 2 ≹⊒N o Give	1	Was Deceden fYes, specify I∐Yes 2€	t of Hispanic Ori Cuban, Mexicar No Specify:	n, Puerto Rio	fy Yes or No can, etc.)		4. Race - Ame Black, Whit Specify:		
5-0036 72 hours aft natural", or	lien.	eted	(Spec	15. Decedent	's Education it grade complete	d)	16a. Dece	dent's Usual C	occupation	t of working		16b. Kir	nd of Business	/Industry	
vithin sne.	S WE	Completed	Elementary/Secon		1	(1-4or 5+)		Mason	done during mos retired)			Se	Lf-Emp1	oved	
filed v Hygic	ent, II	Be ငိ	17. Father's Name (First, Middle,	Last)				18. Mothe	er's Name (I	First, Middle			. J	
Viand Vid be file Mental Hy arked oth	IIIC ev	9 2	Lionel Yo	hn					Mar	garet	Lee D	orsey	7		
Mar and 2 sho alth and 127 is me	er traums		19a. Informant's Na Shirley Y	me/Relationsh ohn (w	njp <i>(Type. Print)</i> ife)		19b. Mailir 1716	ng Address (S Bloom	treet and Numb Rd. West	er or Rural I tminst	er, M	D 21	Town, State, 157	Zip Code)	
Daltimore Dermit. Pages 1 a Department of He mportant: If item	ury or our		20a. Method of Disp ↑ Burial 2 D 4 Donation	Cremation	3 ☐ Removal from	m State St.	Place of Dispo cemetery, crer James	sition (Name natory or othe Cem.	cf r place)	Dat 6/22/2			ings, M		
permit. Departi	any in		21. Signature of Pu	nerel Service	Censee	In-	B 1	Name and Aurrier	Address of Facility Oueen 1	unera berty	l Hom Rd. W	e and	d Crema ed, MD	tory, 21784	P.A.
Physici //Medio Examir	cal		Immediate Cause (disease or condition resulting in death)	rt failure. List Final n	only one cause of	each line			of dying, such as Reced Vive					Approxim Interval E Onset an	date Between d Death
outed d	all oil	Examiner	Sequendary fist cor if any, leading to im- cause. Enter Under Cause (Disease or that initiated events	iditione, mediate rlying injury	Due to	o (or as a consec		e cer		-				250	15
icate be executed physician and the buriel-transit	ile pullar	dical Exa	resulting in death) L	ast	d. Due 1	o (or as a consecuence	quence of:	orli	ı				2 0 000	350	p
ding Physician: The law requires that the death certific h. After this certificate has been signed by the attending p incorporator page 5 should be detached for since as a financial director page 5 should be detached for since as a financial director page 5.	clied for use as	Physician/Mec	IF FEMALE: 23b. Was decedent in the past 12 1 □ Yes 2 □ 9 □ Unknown	months?	1 ☐ Liv	outcome of pregn re birth 2 Pet egnant at time of known	al death 3	∃Ectopic preç ∃Other (spec				2	23d. Date of de Month	livery Day	Year
v requires that: been signed by	io ne della	à	Part II. Other signif	cant condition	ons contributing to	death but not res	sulting in the u	nderlying caus	se given in Part I	l.			se contribute t		
The law recate has bee	one z añar	Completed									24a. Was auto perfe 1 □ Yes		prior to death?	utopsy finding completion of	gs available f cause of
VICAL ician: 1 certifica	.00	Be C	25. Was case referr	ed to medical					1	e of Death (
Physical circles	5 5	၉	1 ☐ Yes 2 ☐ 27. Manner of Death	•		Inpatient 2	ER/Outpatier		<u> </u>				Other (Spe	ecify)	
SION SION Iteriding leath.	5		1 Natural 2 Accident	5 ☐ Pending	g (M	te of Injury onth, Day, Year)	Injury	M 280	Injury at Work? 1 ☐ Yes 2 ☐		d. Describe	now injur	y occurred		
or Atten	n oy me	Certification:	3 Suicide 4 Homicide	6 □ Could r determ	not be 28e. Pla	ce of Injury - At h Iding, etc. (Spec	nome, farm, str ify)	eet, factory, o			f. Location City or To	(Street an wn, State	d Number or F	lural Route N	umber,
DIVISION To the Hospital or Attending within 24 hours a er death. To the Funeral Director. After	netery me	edical C	29a. Certifier (Check only one)			e basis of examin anner stated.	ation and/or in	vestigation, ir	my opinion, de	ath occurred	d at the time	, date and	place, and du	e to the caus	
To th	tion	Me -	29b. Signature and	title of certifier				29c. L	icense number			29d. Da	e signed (Mon	th, Day, Year)
			Jehn	- W-)	mobile	to mid		D	2544	13		6/1	19/2	2009	•
			10	1.4	who completed ca	ause of death (Ite M 'D Registrar's Sign	m 23a) (Type,	Print)	c/		1.	-		40)	1/63
	Stat	e Î	31. Date filed (Mont		LEFON 32	Registrar's Sign	atule	VICTO	ry JA	eet/	1712	nche	STOG	120	1102
Rec	gistra		1	IIN 19	2009	exerce,	p. 1400	761							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Physician** Kichard 6/12/2009 5:30 A HSPI /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **TALBOT** HEARTFIELDS AT EASTON **EASTON** 8. Date of Birth (Month, Day, Year) 11/17/1930 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1**X** M 2□ F MARYLAND Director 193-24-3343 78 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1X Yes 2 □ No Director **CAMBRIDGE** MARYLAND DORCHESTER 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21613 **USA** 410 ROBINSON AVE. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status vvas Decedent EV Armed Forces? 1XYes 2 □ No Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2X No If Yes, Give Year or Dates: 2/15/1963 Specify: Specify: <u>ک</u> 3 Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Flementary/Secondary (0-12) College (1-4or 5+) **EQUIPMENT AND SERVICE TECHNICIAN** COMMUNICATIONS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RALPH PAYNE ASPLEN, SR. HAZEL COLLINS ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7346 HIDDEN COVE, COLUMBIA, MD 21046 GINGER W. GRIFFEY / GRANDDAUGHTER 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Buriai 2 ☐ Cremation 3 ☐ Removal from State 6/17/2009 HURLOCK, MD EASTERN SHORE VETERANS CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sc 22. Name and Address of Facility CURRAN-BROMWELL FUNERAL HOME, P.A., 308 HIGH ST., CAMBRIDGE, MD 21613 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** MINDION disease or condition resulting in death) /Medical Due to (or as a construence of): Examiner will Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Year 5 Other (specify) ☐Yes 2☐No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2500 1 ☐ Yes 1 □Yes 2 🗆 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 6 Other (Specify) FACILTY Hospital: Other: 4 Nursing Home 5 Residence 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27 Manner of Death 28b. Time of 28c. Injury at Work? Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

The law requires that the death certificate be executed Box 68760, P.O. of Vital Records, To the Hospital or Attending Physician: Division

burial-transit attending physician as the nse ō signed by the a d be detached fo page 2 should peen this certificate has director, After thi funeral neral Director: A death.

show

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items 23a

"natural", or

and Mental Hygiene.

permit. Pages 1 and 2:
Department of Health a
Important: If item 27 is
any injury or other trau

2 should be fill and Mental H

72 hours after

Baltimore, Maryland 21215-0036

other traumatic event, the Medical Examinar must be notified at

Medical

State Registrar

completely

hours after within 24 hours a

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

4 Homicide

(Check only one)

29a. Certifier

321 M.D.

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d, Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dorchast Widmark

Combridge,

32. Registrar's Signature

determined

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DHMH 17 Rev 1/2001 24

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month June 20ŎĠ Harry McDonald Barnett, Sr. 4:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Julia Manor Health Care Center Washington Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 01/01/1932 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 12 M 2 ☐ F 214-34-0670 Director 77 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1 ☑ Yes 2 ☐ No Director MD Washington Hagerstown 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 711 Forest Drive US items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married ō Black 1 ☐ Yes 2X No Specify. 3 ☐ Widowed 4 ☐ Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainment. Elementary/Secondary (0-12) College (1-4or 5+) Government Laborer Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edgar (nmn) Nicholas Ada (nmn) Barnett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret E. Barnett / Wife 711 Forest Drive, Hagerstown, MD 21740 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑8urial 2 ☐ Cremation 3 ☐ Removal from State Greenlawn Mem Park 06/09/2009 Williamsport, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licensee 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed physicien and s the burial-transit Box 68760. Physician/Medical attending IF FEMALE for use 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the detached signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Š should t 3 robably Completed 1 Yes 2 No 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an hes le 2 page this certificate of Vital 1☐ Yes 2DNo Attending Physician: director, To Be 25. Was case referred medical examiner? 26. Place eath Check only one 1 Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 ER/Outpatient 3□ DOA within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral 27. Manney of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: Division 1₁□Natural 2 □ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicida 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number. City or Town, State) 4 Thomicide ō To the Hospitel Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Sign ture and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JHT+1

DHMH 17 Rev 1/2001

31. Date filed (Month, State Registrar

2. Reistrar's Signature

81

Anlietam SA HAG MD 2126

			For State Registrar	State of Maryla		artment of H rtificate of L			giene Reg. No	09	19770
-	2		Decedent's Name (First, Middle, Last)					2. Date of De		Veer	3. Time of Death
	Physici	_	Wayne Elmer	Bean				Month May	30, 2	Year 2009	8:27 A ^M
	/Medic Examin	0.01	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of De		4c. County		
		•	Anne Arundel Medi	cal Center		An	napolis	3	Anne	Arur	
100	Funeral		Social Security Number 6. Security Number		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 H	lin. 8. Date of Bir (Month, Da	th v, Year)	9. Birthp	place (State or Foreigntry)
36. ;	Director		207–22–6373	M ^{2□ F} 79	Yrs.	Monare Baye	1,00,0	Oct. 20			sylvania
	pu ,		Usual Residence of Decedent	100	City, Town or Lo	ecation				1	10d. Inside City Limits
	aryla shov d at	<u>_</u>	10a. State 10b. County		Olly, TOWITO LC					1	1⊠Yes 2∐No
	Ba-f	ectc	MD Prince G	eorge's		Bowie			10g. Citizen of	What Cour	ntn/?
	vith the	D I	10e. Street and Number	_		10f. Zip Code 207	15		rog. Citizen of	USA	nuy:
	be filed within 72 hours after death with the Maryland tall Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	12702 Chesney Lan		n II C 10			(Specify Ves or No	. 14. Rac		can Indian,
	er de item	nu	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever i Armed Forces? 1 □XYes 2 □ No	110.5.	If Yes, specify Cuba	an, Mexican, P	(Specify Yes or No uerto Rican, etc.)	Bla	ck, White,	
36	rs aft	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates: 1948	2 52	1 ☐ Yes 2 ZXNo	Specify:		Specif	y: W	hite
8	tura tura	ed	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	ation		16b. Kind of B	lusiness/In	dustry
21215-0036	in 72 n "na Medis	plet	(Specify only highest grad	e completed) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of d)	working			
212	with jiene r tha	Completed	12	College (1-401 54)		Analyst	;		U.S.	GOV	ernment
g	be filed tal Hyg d othe	Be C	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle	, Maiden Surna	me)	
Maryland	Jid be Jenta rked tic ev	To E	Walter I. Bean				Audre	ey I. Ren	ninger		
ary	2 should and Men Is marke		19a. Informant's Name/Relationship (T)	rpe. Print)	19b. Maili	ng Address (Street	and Number o	r Rural Route Numb	er, City or Town	, State, Zip	o Code)
	1 and 2 Health em 27 l		Julie Bisgaard/Da					arksville			
altimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	20 Computal from State	Db. Place of Disposition of the completery, cre	osition (Name of matory or other place	ce)	Date	20c. Location	- City or To	own, State
Ĕ	permit. Pages Department of Important: If It any injury or o		4 □ Donation 5 □ Other (Specify)		Bayview	Crematory	, 6	/3/2009	Baltim	ore,	Maryland
a	permit. Departr Importa any inju		21. Signature Funeral Service Licens	ee		2. Name and Addre		Beall F			
m	e a m e e		04/					wy., Bowi		0715	
,8760,	Physician /Medical Examiner physician and the prival-transit the prival-transit physician and the prival-transit physician and the prival-transit physician and the physician	cal Examiner	23a. Part1. Enter the disease to comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if the leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a coro	nsequence of):	and I	2 Try ailu Tufce	e tron			days days days
.O. Box 68	that the death certificat led by the attending phy detached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	⊒Ectopic pregnanc ⊒ Other (specify) _	у		4 -	ate of deliv	very Day Year
Δ.	res that tigged by		Part II. Other significant conditions co	ntributing to death but no	t resulting in the	ınderlying cause giv	ven in Part I.	23e. Did	tobacco use cor	ntribute to	the cause of death?
ds	requires that leen signed b hould be deta	d by						_ 1 🗆	Yes 2 No	3 ☐ Pro	obably 4 Unknow
Records,	w requir been si should	Completed						24a. Was	s an 24b		topsy findings availab
Re	The law ite has b	E C						perl	opsy formed?	death?	ompletion of cause of
Vital			25. Was case referred to medical				26 Place of	1 Yes Death Check onl	2 No	1 ☐ Yes	2 No
₹	Physiclan: r this certific ral director,	Be c	examiner?	Hospital: 1 Hinpatient	2 ☐ ER/Outpatie	nt 3 DOA Oth	ner:	ng Home 5 ☐ Res		thor /Snac	rifu)
0	Physer this eral di	7: To	27. Manner Death	28a. Date of Injury	28b. Time				how injury occu		1197
On	Attending I r death. ector: After by the funer	tior	1 tural 5 Pending 2 Accident investigation	(Month, Day Yea	ar) Injury		nk?]Yes 2∐No				
Division	To the Hospital or Attendli within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - building, etc. (S		treet, factory, office		28f. Location City or To	(Street and Nun own, State)	nber or Ru	ral Route Number,
	urs a		200 Cartifier 1 Partifying Phy	vsician: To the best of my	/ knowledge dea	th occurred at the ti	ime date and	place, and due to the	e cause(s) and r	manner as	stated
	Hospital 24 hours a Funeral etely filled	Medical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	iner: On the basis of exa and manner stated.	mination and/or i	nvestigation, in my	opinion, death	occurred at the time	e, date and place	e, and due	to the cause(s)
	To the To the Complex	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date sign	ed (Month	ı, Day, Year)
	H S H O		by the Tolan	: MAR		DS	3111		5/3	0/9	
	AXX	D	30. Name and address of person who co	ompleted cause of death	(Item 23a) (Type	, Print)				(/	
	100	3	Hung J. Davis, M			Parkway	Δnna	apolis, M	21401		
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	- ruesway		~ _~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	V-I		

Registrar DHMH 17 Rev 1/2001

State

JUN 0 2 2009

B. park

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Physicia		Decedent's Name (First, Middle, La Dixie C.	Bowie				2. Date of De Month May		, 2009	3. Time of Dea
/Medic Examin		4a. Facility Name (If not institution, gir	ve street and number)		4b. City, Town, or	Location of Death	-	4c.	County of Deat	
Funeral		1301 Largo Road 5. Social Security Number 6.	Sex 7. Age (In yrs.	last birthday)	Upper Ma	arlboro If Under 24 Hrs.	8. Date of Bir	th		eorge's hplace (State or Fo
Director		493-22-7343	1□ M 2□ X F 81	Yrs.	Months Days	Hours Min.	Jan. 3	y, Year) 11, 1		insas
at yieltid AIAID-UUSO should be filed within 72 hours after death with the Maryland nd Mental Hygene. Indexed other than "natural", or Itams 23e or 28e-f show matic event, the Medical Examinar Industrial at	tor	10a. State 10b. County	George's	y, Town or Lo	cation Uppe	er Marlb	oro			10d. Inside City Li 1 ☐ Yes 2 ∑
th the or 28a	Funeral Director	10e. Street and Number	J J		10f. Zip Code			10g. Citi	zen of What Co	ountry?
ath w	ral	1301 Largo Road	T		2077				USA	
ter de Itams Irern	-une	11. Marital Status1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 📉 No	.S. 13. \	Vas Decedent of His f Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No Rican, etc.)	-	 Race - Ame Black, White 	
ours at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		I□Yes 2⊠ No	Specify:			Specify: W	<i>h</i> ite
Paritimities of the state of th	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Deced	lent's Usual Occupa kind of work done do OO NOT use retired)	ition uring most of worki	ing	16b. Ki	nd of Business/	Industry
within ene. than	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	1	stered Nu				Hospita	1
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiden Important: If item 27 is marked other than any injury or other traumatic event, the Meone.	Be Co	17. Father's Name (First, Middle, Las				18. Mother's Name	(First, Middle,			
Menta Menta arked	To B	George T. Carte	r							
2 sho and Is m		19a. Informant's Name/Relationship	**		g Address (Street a					Zip Code)
1 and Health em 27 ther t		John M. Bowie/S 20a. Method of Disposition)1 Largo R sition (Name of		ia, MD Date		4 cation - City or	Town State
ages ent of it: If it y or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Speci	Tuellional linili State		sition (Name of natory or other place abas Cemet					
mit. P Dartme Sortan Injur		21. Signature of Funeral Service Lice		-	. Name and Address		The state of the s		ral Hom	boro, MD
ESESS C		OKY.Z		6	512 NW Cr	ain Hwy.				
Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. Lis on Immediate Cause (Final disease or condition resulting in death)	plications that caused the death one cause on each line. a	ester	e Blue	ding	or respiratory a	mest,		Approximate Interval Betweek Onset and Deat
D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conseq	ae ice of).						
ate be executed hysician and he burial-transit	licai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Du to (or as a conseq	uence of):	the let	-				2
or Attinding Physician: The law requires that the death certificate be examined death. Directur: After this certificate has been signed by the attending physician in by the funeral director, page 2 should be detached for use as the burial	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	Ideath 3	Ectopic pregnancy Other (specify)			2	23d. Date of del Month	ivery Day Year
quires that	by	Part II. Other significant conditions Butt Chr	-	ulting in the ur	nderlying cause give	n in Part I.	23e. Did t	\	<u> </u>	o the cause of death obably 4 DUnkn
The law requate has been page 2 shouk	Completed	atrial Fil	ullation				24a. Was autor perfo		24b. Were au prior to death?	itopsy findings avai completion of cause
ding Physician: The I h. After this certificate he funeral director, page	Be	25. Was case referred to medical examiner?	Hospital:			26. Place of Death				
Physic ruthis cral dir	.: To	1 Yes 2 No 27. Manner of Death	1 □ Inpatient 2 □	ER/Outpatien 28b. Time of	t 3 DOA Dinei	1. 4 ☐ Nursing Hor	me 5 Residence 128d. Describe I			cify)
To the Hospital or Att-nding within 24 hours after death. To the Funaral Directur: After completely filled in by the fune.	Certification:	1 Natural 5 Pending investigation investigation 4 Homicide 5 Pending investigation of the determined for the determined investigation of the determined invest	OB ODE Diese of leiner At he	Injury	M 1 □ Y	? 'es 2 □ No		Street an	d Number or Ru	ural Route Number,
To the Hospital or At within 24 hours alter of To the Funaral Direct completely filled in by	ledicai Ce	29a. Certifier (Check only one) 1 Certifying Pl	nysician: To the best of my kno miner: On the basis of examina and manner stated.	wiedge, death tion and/or inv	occurred at the time restigation, in my opi	e, date and place, a inion, death occurre	and due to the ed at the time,	cause(s) date and	and manner as place, and due	s stated. to the cause(s)
96 0	60		4		29c. Linense	number		29d. Dat	e signed (Mont	h, Day, Year)
To the within 2 To the To the comple	چ ر	29b. Signature and atte of certifier			V43	3276		Jens	- li :	2009
To the within Z	٦	30. Name and address of person who Tiell S O M 31. Date filed (Month, Day, Year)	completed cause of death (Item 32. Registrar's Signa	1 23a) (Type, I	Print) YY	3276 Marloo	MIGN	June	2077	2009 V

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Arthur Franklin Bayer 15.38 2006P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, June 14 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Year Months Min 088-24-8377 89 1920 Maryland Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County 28a-f show d other than "natural", or items 23a or 28a-f showevent, the Medical Examiner must be redified at 1 ☐ Yes 2 No Director Hagerstown Washington Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21742 U.S.A. 14410 Barkdoll Road death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status 72 hours after 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify Specify White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Tool Company Inspector 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be fi Ira F. Bayer Mary Benedict es 1 and 2 should be of Health and Ments fitem 27 is marked other traumatic မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14410 Barkdoll Road Hagerstown, Maryland 21742 (Wife) Frances L. Bayer 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages ' permit. Pages Department of I Important: If ite any Injury or o June 18 1 Burial 2 Cremation 3 Removal from State Ringgold, Maryland Ringgold Cemetery 4 Donation 5 Dother (Specify) 2009 Signature of Funeral Service License 22. Name and Address of Facility J.L. Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Maryland 21783 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or a a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be executed Exami and Due to (or as a consequence of Box 68760. attending physician Physician/Medical the as #F FEMALE nse ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy 20 in the past 12 months? Month 5 ☐ Other (specify) I∐Yes 2 □ No P.0. the be detached 9 Unknown 9 I I Inknown signed by The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, 2 No 3 Probably 4 Unknown 1 □ Yes Completed peen : 24b. Were autopsy findings available prior to completion of cause of death? has autopsy perform this certificate 2 No 2 NO 1 Yes 1 Tyes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | **Z** | **X** | 1 Ampatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of 86 ath 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation (Month, Day, Year) death. 1 ☐Yes 2 ☐No 2 Accident after death filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral L 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature and title

ne and add

31. Date filed (Month, Day, Year)

JUN 19

DHMH 17 Rev 1/200

who completed cause of death (Item 23a) (Type, Print

32

29c. License number

050362

Jefferson Blvd

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 9 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** David Bruce Bennighof 2009 May 28, 6:30 p^{M} /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 603 Church Street Wicomico Sharptown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 01/05/1958 Months Days Hours 1**X** M 2□ F 172-48-3503 51 Pennsylvania Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b County 1 Yes 2 □ No Director Maryland Wicomico Sharptown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 603 Church Street 21861 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: white þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) food manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David Cloyd Bennighof Jessie Huston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau
once. Stephanie Bennighof/sister 2239 River Ridge Rd., Deland, FL 32720 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sharptown Firemans 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/4/09 Sharptown, MD 4 □ Demation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Holloway Funeral Home Professional Association 23a. Part 1. Enter the disease, or complications 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Onset and Death caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) tscv O **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed buriai-tran Due to (or as a consequence of): Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 HInknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 2 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2000 1 □ Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Yes 2 ☐ No Other: 4 In Nursing Home Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 25 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 the of certifie 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title H5049 100 E Carroll St. Salrsky no 2,801 Name and address of personal completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

JUN 0 4 **2009**

32. Registrar's Signature

	1 - State Registrar				Cei	rtificate of	Death			Reg. No. 2	009	19771	**
ician dical	1. Decedent's Name (First, I		·					2.	Date of Dea Month JUNE	Day 4	Year 2009	3. Time of Death 8:05 A M	
niner	4a. Facility Name (If not inst	-				4b. City, Town,	or Location	of Death			unty of Death		
_	HOSPICE CENT					CEN If Under 1 Year	TREVII		Date of Birth		QUEEN A	ANNE 'S place (State or Foreign	-
rai or	5. Social Security Number 220–20–1453 Usual Residence of Deceder		ex □M 2 ∏ F	81	last birthday) Yrs.	Months Days		Min. Al	Date of Birtl (Month, Day UGUST	y, Year) 3, 192 7	Cou	ntry) RYLAND	
	10a. State 10b. Co			10c. Ci	ty, Town or Lo	cation					1	10d. Inside City Limits	-
Director	MARYI.AND (10e. Street and Number	QUEEN	ANNE'S			10f. Zip Code		ENSVIL		10a Citizen	of What Cou	1 ☐ Yes 2 X No	_
a Dir		OE MA	NOR ROA	D			21666				ITED S'		
once. To Be Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐	Married	12. Was Deced Armed Ford 1 □ Yes 2 If Yes, Give Year or Dat	lent Ever in U ces? 2 X No		Was Decedent of If Yes, specify Cu 1 □ Yes 2 X No	Hispanic Or ban, Mexical		fy Yes or No- can, etc.)		Race - Ameri Black, White, ecify: WH	etc.	
Completed	15. Dec (Specify only i	edent's Ed nighest gra	ucation de completed)		I (Give	dent's Usual Occi kind of work done DO NOT use retir	e during mos	t of working		16b. Kind o	of Business/In	adustry	
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■ Baltimore. Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		State of Maryland / De					Jibic.		
		roi	Certificate of De			eg. No. 2	009	19	775
		Decedent's Name (First, Middle, Last)			2. Date of Dear	h	000	3. Time of D	Death
Physicia		Gabrielle Clements			Month O G	G ₃	Year 9	6:30	PM
/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Lo	cation of Death			ty of Death		
الر		2992 West Friends Rd.	Annapoli	S		Anne	Arund	e1	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Months Days F	Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birthp	lace (State or try)	Foreign
Director		377-30-0009	5.		3/23/19	20	Ita]		
and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town o	r Location				1	0d. Inside City	/ Limits
Maryl f sho	힏	Maryland Anne Arundel Annapol	lis					1 ☐ Yes	2 👿 No
h the Marylan or 28a-f show	Director	10e. Street and Number	10f. Zip Code		1	0g. Citizen o	f What Coun	try?	
th with 23a or	a D	2992 West Friends Road	21401			US.	Α		
deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispa If Yes, specify Cuban, I	anic Origin? (Spe	ecify Yes or No-	14. R	ace - Americ		
filed within 72 hours after death with the Maryland Hygiene. Hygiene. The With than "natural", or items 23a or 28a-f show ant, it is invaling Examination notified.		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No xz. ☐ If Yes, Give		Specify:	induity officery	Spec		ite	
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uld be Venta rrked tic ev	To E	Vincent Ferrauiolo	F	elomene	Sanma	rtino			
s 1 and 2 should be filed of Health and Mental Hyy item 27 is marked othe other traumatic event,			lailing Address (Street and	Number or Rura	il Route Numbe	r, City or Tou	ın, State, Zip	Code)	
and and and and and and and and and and			33 Compass Dr						
ges 1 If of H or oth		20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State	isposition (Name of crematory or other place)	1	200	20c. Locatio	-		
t. Pa tmen tant: ijury		4 □ Donation 5 □ Other (Specify) Kalas	Crematory	6/4/2	1 -			arylan	
permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic event once.		21. Signature Funeral Service Licensee	22. Name and Address of 2973 Solomon						
		1 1 2 2 1 1 1 1 1 1					er, m.	Approximate	
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ate b	dical	d							
The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as the	by Physician/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy							
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the d	ysic	1 ☐ Yes 2 MNo 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Dottler (specify)						
that ned b deta	y Ph	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given i	n Part I.	23e. Did to	bacco use co	ontribute to the	ne cause of de	eath?
quires n sig	q p				1 □ Y	es 2 No	3 ☐ Prot	ably 4 🖽 🕽	nknown
s bee	lete				24a. Was a		b. Were auto	psy findings a	vailable
The la	Completed				autops	med? 2 ⊈No	prior to co death? 1 ☐ Yes	mpletion of ca	use of
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hysic his ce I direc	10	examiner? 1 Yes 2 Mo Hospital: 1 Inpatient 2 ER/Outp	atient 3 DOA Other:	4 Nursing Ho	me 5 Resid	ence 6 🗆 (Other (Specia	(y)	
Attending Physician: r death. ector: After this certific by the funeral director.	ü.	27. Manner of Death 28a. Date of Injury 28b. Tin 1 √atural 5 ☐ Pending (Month, Day, Year) Inju	ry Work?	1	28d. Describe h	ow injury occ	urred		
tendi leath. tor: / the fu	cati	2 Accident investigation		s 2 No					
or At after of Direct in by	Certification:	4 ☐ Homicide determined determined 28e. Place of injury - At home, farm building, etc. (Specify)	, street, factory, office	;	28f. Location (S City or Tow		mber or Hura	al Houte Numi	er,
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in		29a. Certifier 1 Certifying Physician: To the best of my knowledge, or	leath occurred at the time	date and place	and due to the	cause(s) and	manner as	stated.	
e Hos 124 h e Fur	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/one and manner stated.	or investigation, in my opin	ion, death occur	ed at the time, o	ate and plac	e, and due t	the cause(s)	
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physi completely filled in by the funeral director, page 2 should be detached for use as the total completely filled.	Me	29b. Signature and title of pertifier	29c. License no	umber	2	29d. Date sig	ned (Month,	Day, Year)	
		Mildimalo	D5	1819	-	June	.04	200	9
3.		30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print) Matthew	J. :Ma1+	a. M D		10.		
ω		132 174.10 7 01 000/6 20	I, Ann	4 po 1.5	W.D.	21	10)		
Sta Registra	_	31. Date filed (Month, Day, Year) JUN 0 4 2009 Registrar's Signature	Sauce						
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			Pleas 1_For State	e Type or Prin	aryland / D	epar	tment of H	lealth and	•		•		
			Registrar		(Cert	ificate of	Death	0.0	Reg. N	2009		9771
	Physici /Medic		1. Decedent's Name (First, Middle, Macie Marie C	larke					2. Date of De Month June		ay Year 2009		ime of Death 40 A M
***	Examir	ner	4a. Facility Name (If not institution, Anne Arundel Me		er	4		r Location of Dea Annapoli		44	c. County of Deat Anne A		el
	Funeral Director		216-84-1875	5. Sex 7. Ag 1 □ M 2 🔀 F	e (In yrs. last birth 74 Y		If Under 1 Year Months Days	If Under 24 Hr. Hours Mir		rth ay, Year 12,	9. Bird Co	untry)	State or Foreign ginia
	aryland show dat	5	Usual Residence of Decedent 10a. State 10b. County Maryland Anne	Arundel	10c. City, Town	or Loca		nnapolis					side City Limits ☐Yes 2171110
	with the M a or 28a-f be notifie	Director	10e. Street and Number 34 Oak Court				10f. Zip Code	21401		10g. C	itizen of What Co		
336	be filed within 72 hours after death with the Maryland tial Hygiene. d other than "natural", or items 23a or 28a-f show event, it a fledical Evantia primist be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 Yes, Give Year or Dates:					Specify Yes or Norto Rican, etc.)	0-	14. Race - Ame Black, White Specify:		
1215-0036	in 72 hou "edical E	Completed by	15. Decedent's (Specify only highest	Education grade completed)	(Give kir	nt's Usual Occup nd of work done O NOT use retired	during most of we	orking	16b. I	Kind of Business/	Industry	
.7.	d with giene er tha	lo m	Elementary/Secondary (0-12)	College (1-4or 5)+)	В	aby Sit	ter			Child	Care	
Baitimore, Maryland 2	be od of o	To Be (17. Father's Name (First, Middle, La William Toney	ıst)					_{ime (First, Middle} ie Sue J				
Mar	- C W =		19a. Informant's Name/Relationship Paul A. Clarke,						Rural Route Numb		or Town, State, 2nd 2140)
more,	of H		20a. Method of Disposition 1 □ Cremation 3 4 □ Donation 5 □ Other (Spe	Removal from State	1		tion (Name of tory or other place		Date 5 / 2009		ocation - City or		
Bait	permit. Page Department (Important: If any injury or once.		21. Signature of uneral Service Li	7		22. 1	Name and Addre	ss of Facility J	ohn M. T	aylo	or Funera	al H	
	Physician /Medical		23a. Part 1. Enter the disease, or construction shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	Resp	the death. Do no	r enter Fai	the mode of dyin				ELECTIS!	Appro	oximate val Between ot and Death
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (or as	ral Effu a consequence of gestive H):		re					
68/60,	eath certificate be executed attending physician and for use as the burial-transit		that initiated events resulting in death) Last	Due to (or as	a consequence of):							
. O. BOX 6	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death		Ectopic pregnanc Other (specify) _	у			23d. Date of de Month	livery Day	Year
as, r	e law requires that the di has been signed by the le 2 should be detached	by	Part II. Other significant condition Atrial Fibril		ut not resulting in t	he und	erlying cause giv	en in Part I.			use contribute to		
Vital Records,	e law req has beer ge 2 shoul	Completed	Coagulopathy						24a. Was	an	24b. Were au	utopsy fin	ndings available on of cause of
<u></u>	in: Th ifficate or, pag		25. Was case referred to medical					00 Pl (P	1 □Yes	2 X N		2 🗆 N	lo
<u> </u>	ysicia is ceri direct	To Be	examiner? 1 ☐ Yes 2√2√No	Hospital:	ent 2 🗆 ER/Outp	atient	3 □ DOA Oth	or:	eath (Check only Home 5□ Res		6 ☐ Other (Spe	ecify)	
VISION OF	nding Ph ath. r: After th e funeral	ation: T	27. Manner of Death 1 双翼atural 5 □ Pending 2 □ Accident investigat	28a. Date of Inju (Month, Da	ry 28b. Tir		28c. Injui Wor		28d. Describe				
DIVIS	al or Atte s after des Il Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ury - At home, farn c. (Specify)	n, stree	t, factory, office		28f. Location City or To		and Number or Ri te)	ural Rout	e Number,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical (29a. Certifier (Check only one)	Physician: To the best caminer: On the basis o and manner sta	f examination and	death o	occurred at the ti stigation, in my o	me, date and place opinion, death occ	ce, and due to the curred at the time	e cause , date ar	(s) and manner and place, and due	s stated.	ause(s)
	To the To the Complex complex	Me	29b. Signature and file of certifier	Lifn			29c. Licens	e number D 4337	1	29d. D	ate signed (Mont 6/1/2009		'ear)
Zit	12		30. Name and address of person wi	no completed cause of d				s, Marv	land 21	401			
	Sta Registr		31 Date filed (Month Day Vear)	2009 32. Registra	ar's Signaturo								
		004				1							

09-04413 Shai Caldwell

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 19777

		For State Of Maryand / Department of the Registrar 6-8-09 Amen #10c PerFHPOCC Certificate of De		Reg.	No.	
Physicia	ın/	1. Decedents Name (First, Middle, Last)		Date of Death Month D	ay Year	3. Time of Death
ledical Exami	ner	Shai Roxanne Caldwell	y, Town, or Location of Death	June 3, 2009	9 4c. County of Death	0033 hrs
		,	y, Town, or Location of Death e verl y		Prince George	's
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If U	Inder 1 Year If Under 24Hrs.	_		nplace (State or Foreign
Director		220-27-9037 1 M 2xF 19 Yrs.	onths Days Hours Min.			aryland
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
*	٦	MD Prince Georges 4001 Windf:	lower Way Bo	owie, M	20720	1 Yes 2 X No
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 10f.	Zip Code	10g.	. Citizen of What Coun	itry?
with the	<u>a</u>	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Dec	20720 edent of Hispanic Origin? (Sp	ecify Yes or No-		can Indian, Black,
death	Funeral	X Never Married 2 Married 1 Yes 2 X No	ecify Cuban, Mexican, Puerto	Rican, etc.)	White, etc. Black	ς
s after iral",	ā	or Dates:	2 X No specify: ual Occupation (Give kind of v	vork done	Specify: 6b. Kind of Business/li	ndustry
72 hour	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	working life. DO NOT use reti	red)		,
036 vithin 7 ene. er thar	du		l Billing Sp		Healthca	are
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica		17. Father's Name (First, Middle, Last)	18.Mother's Name		,	
212 ould be d Menta s mark	To Be	Norman Van Cousins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addr	SVIV1a ress (Street and Number or F	R . Calo	OWELL er, City or Town, State	, Zip Code)
MD nd 2 sho alth and m 27 is		Sylvia R. Caldwell- mother 4001		Vay Bow	ie, MD 20 20c. Location - City or	720 Town State
Baltimore, permit. Pages I an Department of Hea important: If iter		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition (crematory or other pla	ace)		•	
Itim it. Pag utiment urtiment y or ot		4 Donation 5 Other Specify: Ardent Cre 21 Synatyre of Funera Sprvige Longe 22. Name			Hanover, ntic Crem	
Ba perm Depa Impo		Donas Mensey 7829	Belle Pt. I	or. Gree	enbelt, N	
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mo failure. List only one cause on each line.	de of dying, such as cardiac o	r respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
/Medical xaminer		Immediate Cause (Final disease or condition resulting in death) a. Gunshot Wound of Torso Due to (or as a consequence of):				Death
		Sequentially list conditions, b				
	miner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
ed usit	Exam	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	d. UNPENDED AMENDED	<u> </u>			
760, ficate be g physic the bur		IF FEMALE: 23c. If yes, outcome of pregnancy	-uh 3 Estavia pro-re	anov	23d. Date of deliver	y Day Year
Box 687 death certification at the attending of the total as as the	sician	past 12 months? A Pregnant at time of death 5 Other (see)		aricy	Month [Jay rear
BO) he death	Physi	1 Yes 2 No 9 V Unknown g Unknown		230 Did tob	acco use contribute to	the cause of death?
ords, P.O. v requires that the sbeen signed by the should be detached.	þ	Part II. Other significant conditions contributing to death but not resulting in the under	ying cause given in Part I.		2 ✓ No 3 Proi	
ords, w require s been si should b	Completed			24a. Was an		itopsy findings available completion of cause of
The law ate has age 2 s	omp			perform 1 Y Yes 2	ned? death?	
Vital Reco ysician: The law his certificate has director, page 2 s	Be C	25. Was case referred to medical examiner?	26.Place of Death (Check			
F Vit Physic or this c	To E	1 ✓ Yes 2 No Inpatient 2 ✓ ER/Outpatient 3	DOA Other Nursin		esidence 6 Othe	r:
Division of Vital Records, tal or Attending Physician: The law requir rs after death al Director: After this certificate has been sted in by the funeral director, page 2 should	tion:	1 Natural 5 Pending Jun 2, 2009 2350 hrs	1 Yes 2 ✓ No	Subject shot	injury occurred	
Visio	ertification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fac	etory, office building, etc.	28f. Location (Stror Town, Sta		ural Route Number, City
Divis spital or At hours after d meral Direct y filled in by	Cert	4 V Homicide determined (Specify) Sidewalk		9009 Continent	al Drive, Hyattsville	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in	t the time, date and place, and n my opinion, death occurred	d due to the cause at the time, date ar	(s) and manner as stated and place, and due to the	ted. ne cause(s)
To with To COM	Mec	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Mo	
		Carde Hallan	O.C.M.E.		June 3, 2009	
25		Name and address of person who completed cause of death (Item 23a) Carol Allan, MD	et, Baltimore, MD 2120)1		
	ate		5, 50,1,1,1010, 1410 2120			
Regist	rar	31. Date filed (Month, Day Year) JUN 0 8 2009 32. Register's Signeture				

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1131 EDRACE **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 7/4/1943 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Min Pennsylvania Yrs Director 180-36-0100 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10h. County 10a State "natural", or items 23a or 28a-f show dical Examinat must be notified at 1 ☐ Yes 2 No Funeral Director Stevensville Maryland Queen Anne 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21666 413 Creeks End Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🕅 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: White 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation traumatic event, the Wedical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Commercial Banker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lucille Ellithorp ၉ George Franklin Cormeny, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important; if item 27 is any injury or other trau once. 413 Creeks End Lane Stevensville, MD. 21666 Brenda E. Cormeny/Wife Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Edgewater, MAryland 6/1/2009 Kalas Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home Funeral Service Licenses 2973 Solomons Island Rd. Edgewater, MD. 21037 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
HMUNDHS Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed and burial-tra Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the as attending properties as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) the 9 Unknown þ signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed? certificate I 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1. Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d Date signed (Month, Day, Year) 29b. Signature and title of certification

Registrar

Name and address of person

31. Date filed (Month, Day, Year)

JUN 01

FENSE IT GHWAY

who completed cause of death (Item 23a) (Type, Prip

Registrar's Signature

Division of Vital Records, P.O. Box 68760,

			Type or Print in B State of Maryland						0000	19779
	•	1 - For State Registrar	,	•	rtificate of			Reg. No		
Physicia	an	1, Decedent's Name (First, Middle, La	·				2. Date of D Month	Da		3. Time of Death
/Medic Examin		Marcus Vess (4a. Facility Name (If not institution, gir			4b. City. Town, o	r Location of Deatl	may	30 4c	200 9. County of Death	ASTO
/ Examini	eı	PENINSULA REGIONA,		111		alistacy			HICIAIOS	
Funeral		Social Security Number 6.	Sex 7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	lay, Year)	9. Birth Cou	place (State or Foreign ntry)
Director		529-38-5034 Usual Residence of Decedent	78	Yrs.			July 20), 19	30 Utah	
/land		10a. State 10b. County	10c. City	Town or Lo	cation					10d. Inside City Limits
Mary a-fsh	tor	MD Wico	omico I	Pittsv	ille					1⊠Yes 2□No
th with the Marylan 23a or 28a-f show	Director	10e. Street and Number			10f. Zip Code			10g. Ci	tizen of What Cou	ntry?
ath wi		34682 Heartland			21850				U.S.A.	
er death w items 23a	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever in U.S Armed Forces? 1 XYes 2 No 195	6_ 13.\	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert	pecify Yes or N o Rican, etc.)	0-	 Race - Ameri Black, White, 	
be filed within 72 hours after death with the Maryland tall Hygiene. Additional death than "natural", or items 23a or 28a-f show event, the Maryland Event in the Maryland at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: 196		1∐Yes 2⊠No	Specify:			Specify: W	hite
"natural", or	Completed	15. Decedent's E (Specify only highest gr	ducation	16a. Dece	dent's Usual Occup	pation	kina	16b. K	(ind of Business/In	dustry
ithin 7 ne. nan "r	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	kind of work done DO NOT use retired	d)	King			
led w dygier her th		17. Father's Name (First, Middle, Lasi	8		Teacher	18. Mother's Nan	o (Eiret Middle	o Maidar	High Sc	hool
d be fi	Be	Robert Vessie Ca				Ethelyr			i Sumame)	
should nd Me mark	2	19a. Informant's Name/Relationship		19b. Mailir	ng Address (Street				or Town, State, Zi	Code)
nd 2 salth a 27 is 27 is strat		Joy Olsen Carver		3468	2 Heartla	and Drive	. Pitts	svil1	e, MD 2	1850
of He of He rothe	-	20a. Method of Disposition	20b. Pla		sition (Name of natory or other place	i i	Date 5, 200	20c. L	ocation - City or To	own, State
Page ment ant: It		1 XI Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	□ Hemovai from State		hore Vete	June			lock, Ma	ryland
permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "in any Injury or other traumatic event, in the conce.		21. Signature of Funeral Service Lice	1	22	2. Name and Addre Short Fu	ss of Facility neral Ho	ne			
⊕⊓= # Ø			Thewell			Grove St			r, DE 1	9940 Approximate
		23a. Part 1. Entaythe disease, or com shock, or heart failure. List only Immediate Cause (Final				ng, such as cardia	or respiratory	arrest,	1	Interval Between Onset and Death
Physician / /Medical		disease or condition resulting in death)	a. Vilyocir		1 (2+5)	NETOU				hours
Examiner			Due to (or as a consequence of the consequence of t	C244	wtery	disea	50			60005
7 +	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequent	_		0.13 CC	, ,			
e executed an and irial-transit	Examiner	Cause (Disease or injury that initiated events	C							
	=1	resulting in death) Last	Due to (or as a consequent	ence of):						
physi	Physician/Medica		d							
certif nding Ise as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar						23d. Date of deliv	ver v
death e atte	iciar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		Ectopic pregnanc Other (specify)	У			Month	Day Year
by the	hys	9 Unknown	9 Unknown							
ding Physician: The law requires that the death certificate bn. After this certificate has been signed by the attending physici funeral director, page 2 should be detached for use as the bu	δy	Part II. Other significant conditions	contributing to death but not resul	ting in the ur	nderlying cause giv	en in Part I.				the cause of death?
requir een s nou ld	ted						1	Yes 2	Pro 3 ☐ Pro	bably 4 ☐ Unknown
e 2 st	Completed						24a. Wa auto	opsv	prior to co	opsy findings available ompletion of cause of
r: The ficate r, pag	ဝိ						1 □ Yes	formed? 2 Z No	death? o 1 ☐ Yes	2 🗷 No
sicial certii irecto	Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 ☐ No	Hospital: 1 Inpatient 2 E	D/Outrotion	oth Oth	er:			0 Floth (0)	
g Phy er this eral d	μ̈́	27. Manner of Death	28a. Date of Injury	28b. Time of	IL 3 LI DOA	4 LI Nursing F	28d. Describe		6 ☐Other (Spec	iry)
ath. r: Aft	atio	1 Natural 5 Pending 2 Accident investigatio	(Month, Day, Year) n	Injury		k? Yes 2 □ No				
r Atte er de recto	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined		ne, farm, str	eet, factory, office			(Street a	nd Number or Rui	al Route Number,
oital o urs af eral Di	Se									
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur	Medical	29a. Certifier (Check only one) 1. Certifying P 2 Medical Exa	hysician: To the best of my know miner: On the basis of examinati and manner stated.	on and/or in	vestigation, in my	ppinion, death occu	irred at the time	e. date ar	nd place, and due	to the cause(s)
o the	Mec	29b. Signature and title of certifier	and marmer stated.		29c. Licens	se number		29d. Da	ate signed (Month	, Day, Year)
and		> Xtas	5		D3	6783		m	94 31,0	2009
JUA	}	30. Name and address of person who	completed cause of death (Item	23a) (Type,	Print)	- 1 1			7	
1011		JESPREY EthERION	MD LOOE	Anno	Print)	SAlisbu	Ry Ma	21	1801	
Stat		31. Date filed (Month, Day, Year)	32. Jegistrar's Signatu	1. A	arke		/			
Registra	al .	JUNU 4	.000	• •						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Day Physician 8:09 PM 2009 Mav 28 Helen Louise Coffman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min Hours 1 □ M 2 🕅 F Months Davs Yrs Washington, D.C. Director 04/15/1929 578-38-0589 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural"
any injury or other traumatic event. 10d. Inside City Limits 10c City Town or Location 10h County 1 ☐ Yes 2X No **Funeral Director** Maryland | Calvert North Beach 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20714 United States 3710 8th Street 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X☐ No Specify Specify ģ 3 Widowed 4 Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) State Agriculture Department Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Cecelia Williams Herbert Peter Jordon ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3710 8th Street, North Beach, Maryland 20714 Lori H. Walton/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Kalas Crematory 06/04/2009 Edgewater, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityGeorge P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 NO 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only

DHMH 17 Rev 1/2001

State

Registrar

29b. Signature and title of certif

31. Date filed (Month, Day, Year)

Daliest Singh Sidhu

JUN 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

205 Crain Huy SW Glen Burnie

29d. Date signed (Month, Day, Year)

2106

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ roi	partment of Health and I	Mental Hygi	iene	10701
			***************************************	ertificate of Death		eg. No Z U U 9	19/81
	Physicia		1.Decedent's Name <i>(First, Middle, Last)</i> Donald Everette Dillard		2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	<u> May 28,</u>	4c. County of Death	11:45A **
1			101 Farragut Road	Annapolis		Anne Arun	del
	Funeral		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthdi	Months Days Hours Min	8. Date of Birth (Month, Day, Feb. 08, 1	Year) 9. Birth	nplace (State or Foreign untry) SOUTI
	Director		217-30-0020 X 74 Yrs Usual Residence of Decedent		rep.00,1	933 1113	30011
	show	_	10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	he Ma 28a-f	Director	Maryland Anne Arundel	Annapolis	140	Og. Citizen of What Co	1√ Yes 2 No
	with t		101 Farragut Road	10f. Zip Code 21403		nited Stat	,
	death	Funeral		3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert		14. Race - Amer	ican Indian,
36	Id be filed within 72 hours after death with the Maryland fental Hygiene. *Red other than "natural", or items 23a or 28a-f show ite event, the Medical Examinar in ust by multihed at	by Fu	1 ☐ Never Married 2 🖾 Married 1 📆 Yes 2 ☐ No ☐ If Yes, Give	1 □Yes 2 ☑ No Specify:	o nicari, etc.	Black, White	
21215-0036	hours Itural		3 ☐ Widowed 4 ☐ Divorced Year or Dates: 5,5 15. Decedent's Education 16a. De	cedent's Usual Occupation	1	16b. Kind of Business/I	hite
212	hin 72 e. an "na Medio	Completed	(Specify only highest grade completed) (G Elementary/Secondary (0-12) College (1-4or 5+)	ive kind of work done during most of wor . DO NOT use retired)	king		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
7	ed with	Con	2	Disc Jockey		Radio	
yland	be fill ntal H ed oth	Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, M		
>	Shou od N mar mat	ပ္	Everette Lester Dillard 19a. Informant's Name/Relationship (Type. Print) 19b. M:	ailing Address (Street and Number or Ru	an Harrie ural Boute Number.		in Code)
Mar	alth al 27 is er trau	1 3		Farragut Road, An		•	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
ore,	es 1 a of He of Item	1	20a. Method of Disposition 20b. Place of Discomptence	sposition (Name of rematory or other place)		20c. Location - City or T	Fown, State
Бапттог	. Pag tment tant: I jury o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimo	re Crematory 6/1/	09 B	Baltimore.	Maryland
ga	permit. Pages 1 and 2 Department of Health a Important; If Item 27 is any Injury or other tra		21. Signature of Funeral Service Licensee			ylor Funer	
			23a. Part1. Enter the disease, or complications that caused the death. Do not	147 Duke of Glouces	-		MD 21401 Approximate Interval Between
	Physician	67. 9	shock, or heart failure. List only one cause on each line. Immediate Cause (Final	1000 H-1201			Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	May to course			
	Examiner	Ļ	Sequentially list conditions, b.	artey 0,50	ase_		
	nsit ns	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated appears)	J			
<u>-</u>	execun and ial-tra	Examine	that initiated events resulting in death) Last c. Due to (or as a consequence of):				
0/9	Ine law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical	d				
õ ×	ding p		IF FEMALE: 23c. If yes, outcome of pregnancy				-
Š O	atten for us	sician/Me	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deli Month	very Day Year
	t the c by the ached	Physi	1 Yes 2 No 9 Unknown				
'n.	es tha igned be det	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to	
cords	requir bould				1 ☐ Ye:	13	obably 4 🗌 Unknown
9	ne law has b ge 2 sl	Completed			24a. Was an autopsy perform	y prior to c	topsy findings available completion of cause of
Ia.	an; Irr tificate or, pa	ပို	25. Was case referred to medical	26. Place of Dec	1 ☐ Yes 2	XNo 1 ☐ Yes	2 □ No
<u> </u>	lysicia iis cer direct	P B	examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	Other:	3.4	nce 6 ☐ Other (Spec	cify)
	ng Pro	L:uo	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 28b. Time (Month, Day, Year)		28d. Describe how	w injury occurred	,
2	ttend death. ttor: A the fu	icati	2 Accident Investigation	M 1 □Yes 2 □No	OPA Lagation (Ct.)		and Davids Alicentes
2	after after Direct d in by	Certification:	4 ☐ Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	City or Town,	reet and Number or Ru , State)	rai noute ivumber,
	To the hospital or Attending Prysician; The law requires that the death certinities to the force of the thinks of the function of the Function of the Function of the function		29a. Certifier (Check only (Check only 2 Medical Examiner: On the basis of examination and/o	eath occurred at the time, date and place	i e, and due to the ca	ause(s) and manner as	stated.
,	thin 24	Medical	one) and manner stated.				
	2 3 4 8		29b. Signature and title of certifier	29c. License number) 28	Od. Date signed (Month	2009
	hal		30, Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)	X .	180100	
	.4		Andria I Garlt MS	CP, Annapol	is mi	>	
	Stat Registra		31. Date filed (Month, Day, Year) JUN 01 2009 32. Degistrar's Signature	he del			
	-		Lancon D.	PACIFIC			

Registrar

DHMH 17 Rev 1/2001

Mr

State

29a. Certifier

(Check only

29b. Signature and title of certifier

Medical

32. Registrar's Signature

1 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For		icasc	State			/ Depa	artment of			lental Hy	giene	000	197	83
			= Stete Registrer	Nama /First	Middle 1a	otl			Cei	tificate of	Death		2. Date of De	Reg. No.	. 0 0 2	3. Time of D	Death
П	Physicia	_	1. Decedents in	+ Lan	1	Edie	ronde	5					Month.	Day	2009	2117	MA
	/Medic Examin	_	4a. Facility Nan				umber)	1		4b. City, Town,	() .				County of De	ath	
Н			SHO	ock.		Luma				B G If Under 1 Yea	1 time	24 Hrs.		th .	N/A	irtholace (State or	Foreian
П	Funeral Director		5. Social Secur 21 6- 28		6. S	ex ДМ 2□ F	7. Age (In		7 Yrs.	Months Day		Min.	8. Date of Bir (Month, Da May 14	y, Year) 4 19:	32 M	inthplace (State or Country)	, o. o.g.,
_	D.	-	Usual Residend		ent		100	City T	own or Lo	Lantion .			,===-/			10d. Inside City	Limits
	Aaryla f shov	ō				rundel		-		ills						1 ☐ Yes	
	r 28a-	rect	10e. Street and	Number						10f. Zip Code				10g. Citiz	zen of What (Country?	
	death with the Maryland ms 23a or 28a-f show r must be notified at	TaiD	2500 N	Mayti	me D	r.					054				USA	to a to do	
		Fune	larylar 10e. Street and 2500 N 11. Marital Stat 1 \(\text{ Never } \)	tus Married 2 📮	X Married	12. Was De Armed I	cedent Ever orces? 2 🗍 No Sive	in U.S.		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ N			ecify Yes or No Rican, etc.)		Black, Wh		
003	hours efter tursi', or ite el Eventine	۵	3 🗌 Widow	red 4 ∐ Div	orced	Year or	Dates:W . \	,	ГТ						nd of Busines		
5	within 72 Pene. then "nati	Completed		Specify only		ide completed		'	(Give	dent's Usual Occ kind of work don DO NOT use reti	ne during mo:	st of work	ing	100, 11	Id of Edsiries	symoustry	
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Maryland 21215-0036	be filed stel Hygic of other svant, it	Be	17. Father's Na Richal										e (First, Middle A. Jo		Sumame)		
<u> </u>	s 1 and 2 should be f Health and Mentel itsm 27 is marked o othsr trsumatic svs	은	19a. Informani						19b. Maili	ng Address (Stre	1				r Town, State	, Zip Code)	
Na Na	tra fig		Christ	tine :	Edwa	rds(Wi	fe)	2	2500	Maytir	me Dr		Sambri:				
ore	Peges 1 and of He not of He int: If itsm iny or oth		20a. Method of	•	ation 3	Removal from	n State	cem	etery, cre	sition (Name of matory or other p			Date			or Town, State 11e, Md	
Baltimore,	그 된 된 글 .		4 ☐Donat 21. Signature	tion 5 Ott				Mary	103	d Vetei MvameRæed			5-09 Morti				•
Ba	Depa Impo sny ir		Far		. 1	=M0048	8			21 West				_			
			shock, or	r heart failure	ase, or come. List only	plications that one cause or	t caused the each line.	death.	Do not en	ter the mode of d	11	1				Approximate Interval Betw Onset and D	veen
	Physician /Medical		Immediate Ca disease or cor resulting in de	ndition		a	NICO Oprasa co	7101	15	of mu	H: P	101	njurie	·S			
	Examiner		Carrantiniba ii	ist sonditions	- 1	h	5,5 01 as a co	i i seque	100 01).								
	pe sit	iner	Sequentially li if any, leading cause. Enter Cause (Diseas	to immediate Underlying	·₹	Due t	o (or as a co	nsequer	nce of):								
	te be executed ysicien and e burial-transit	Examiner	that initiated er resulting in de	vents	1	c	o (or as a co	nsequer	nce of):								
1760,	ysiciently buri	ca			·	d											
89 X	ertifica ding ph	Med	IF FEMALE:			23c. if yes, o	utcome of n	rognanc	· · · · · · · · · · · · · · · · · · ·						Old Date of	delines	
Вох	death c	by Physician/Medi		edent pregna st 12 months 2 \(\sumbole \text{No}\)		1□Live 4□Pre	birth 2 gnant at time	Fetal de	eath 3[⊒Ectopic pregnar ⊒ Other <i>(specify)</i>					23d. Date of Month		'ear
o.	at the classification of the classification	hys	9 🗆 Unkr	nown		9□ Uni							20. 014				anth?
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	d by	Part II. Other s	significent co	onditions	CONTRIBUTING TO	death but no	ot resulti	ng in the u	inderlying cause	given in Part	t I.		Yes 2		Probably 4	Jnknown
CO	s beer 2 shou	Completed	My	OCGI	dial	inf	arcti	on					24a. Wa	s an	24b. Were	autopsy findings a to completion of ca	available
E Be	The la	Com	Ac	1110	rei	10/	ailue	F					per 1 🗆 Yes	formed?	death	?	
Vita	ician: certific rector.	Be	25. Was case examiner?		nedical	Hospital:	4				Other		th (Check only		a [] Otto: (6		
ō	g Phys er this eral di	n: To	1 Yes 27. Manner of	Death			inpatient te of Injury onth, Day Ye	2	8b. Time of Injury		njury at Nork?	vursing H	ome 5 Res			hit back	
101	andin eath. or: Aft he fun	catio	1 Natura 2 Accid	ent	Pending investigation Could not the court of the court	n 65-1	7-200	7 2	1561		□Yes 2	ĎΝο	oftn	acti	on tre	: len	
<u>×</u>	or Att after de Direct	Certification:	3 ☐ Suicio 4 ☐ Homi		determined	200. FIG	Iding, etc. (S	Specify)		reet, factory, offic	ce		City or To	(Street an own, State	Number of	Rural Route Num.	è Rd
-	Hospital 24 hours a Funeral I		29a. Certifier	1[] 0	ertifying P	hysicien: To	the best of m	y knowle	edge dea	th occurred at the	e time, date a	and place	, and due to the	e cause(s	and manne	as stated.	Λ.
	To the Ho within 24 To the Fu	Aedicai	(Check or one)	1		miner: On the	anner stated	aminatio	n and/or ii				rred at the time			due to the cause(s	
	To Co	Σ	29b. Signatur	and the of	Certifier	N	Do	5,4	\	3	SGL	7		-			
f2	المال	1	30. Name and	address of p	person who	completed ca	use of deat	(Item 2	3a) (Type	, Print)	1	, /1		70	INIC	2,2009 Le Md Zi	
4	HUH		Ph	1,7	M:	l: te	No Postrar's	4 D	6	Trimb	ole 1	4:1/	CT. L.	uth	Druill	6 WGS	1093
	Sta Registi		31. Date filed	JUN		2009	President			back							
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DHMH 17 Rev 1/2001

		Plea	se Type or Pri								.egible) .	
		For State Registrar	State of M	aryiano /		artment of F ctificate of		and ivier	пап пу	Reg. No.	200	9	19784
		Decedent's Name (First, Middle	e, Last)						Date of De		Ye		3. Time of Death
Physicia /Medica		Bruce Henry FI	NK 					-	Tune	00	, 20	90	11:32 PM
Examine	er	4a. Facility Name (If not institution				4b. City, Town, o					County of D		-
Funeral		Washington Courses. Social Security Number		je (In yrs. last	birthday)	If Under 1 Year	rstow	24 Hrs. 8	Date of Bir (Month, Da	th	Washi		e (State or Foreign
Director		215-26-2033	1 🕱 M 2 🗆 F	76	Yrs.	Months Days	Hours	Min. Fe	b. 20), 19	33 M	ary1	
land Dw	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation						10d.	Inside City Limits
the Maryland r 28a-f show r offied at	ķ	Maryland Was	hington		Hage	rstown							1 □Yes 2 No
or 28%	Funeral Director	10e. Street and Number				10f. Zip Code					en of What	Country	?
s 23a	eral	10834 Roessner		5	140.1		1740	-ing (Charif	. Voc or Ne	US	A 4. Race - A	morican	Indian
fter dea	Ē	11. Marital Status 1 ☑ Never Married 2 ☐ Marri	12. Was Decedent Armed Forces? ried 1 XYes 2 □			Was Decedent of H f Yes, specify Cubi			an, etc.)			/hite, etc.	
ours aff	<u>م</u>	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	1951-5	5 1	I∐Yes 2⊠No	Specify:				Specify:	whi	te
within 72 hours after death with the Marylanc iene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	letec	15. Deceden (Specify only highe	it's Education st grade completed)	11	6a. Deced	lent's Usual Occup kind of work done OO NOT use retired	oation during most	t of working		16b. Kin	nd of Busine	ess/Indus	try
withir jiene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	_	enance a	_			st	ate g	over	nment
e filed al Hyg I other vent,	Be C	17. Father's Name (First, Middle,	*	,				er's Name (F			Surname)		
ould b	٥	Ernest C. Fink						line Z					
permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "n any Injury or other traumatic event, It is Mode.		19a. Informant's Name/Relations C. Douglas Fore				g Address <i>(Street</i> Banniste							
s 1 an of Hea item 2		20a. Method of Disposition		20b. Place		sition (Name of natory or other place		Date			cation - City		
Page Trent cant: If ury or		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S				Cemeter		6/12/0	9	Hage	rstow	n, M	aryland
permit. Departimport. any inj		21. Signature of Funeral Service	Licensee		/	. Name and Addre		LITIN			RAL H		4 0
462 % G	_	25e: Part 1. Enter the disease, or	r complications that cause	d the death. I		15 E. Wil.					wn, Me		L/4U pproximate iterval Between
Physician		shock, or heart failure. List Immediate Cause (Final	only one cause on each	ine.	CI	onck.	3,					In O	nset and Death
/Medical		disease or condition resulting in death)	Due to (or as	a consequence	ر e of):	1000		1 / '				OA.	CWEEK
Examiner	١	Sequentially list conditions,	b	ostrio	lium	Diffice	le C	oliti	ς			100	re weeks
nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence	ce oi):	v10						Tu	ve weeks
e executed an and rial-transit	Exa	resulting in death) Last	CDue to (or as	a consequence	ce of):	* 1 () (1	
eath certificate be executed attending physician and for use as the burial-fransit	lical		L d										
certific ding p	Physician/Medica	IF FEMALE:	23c. If yes, outcome	e of pregnancy							23d. Date o	f delivery	
death a atten d for u	ician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant	2 Fetal de	ath 3⊑	☐ Ectopic pregnand ☐ Other (specify) _	СУ				Month	Da	
w requires that the dispersion is been signed by the should be detached	hys	9 Unknown	9 □ Unknown										
res that	ু হ	Part II. Other significant condition	ons contributing to death t	1	- /	4-0							cause of death?
v requ	Completed		Endobic	- ba	-	Thrua l desce	201	4	24a. Was		1		y findings available
he law te has age 2 a	d mc		Cha Stacy		<i>M</i>	(201 SC	NVC		auto perf	opsy ormed?	prio dea	r to comp th?	detion of cause of
ian: T rtificat tor, pa	e l	25. Was case referred to medica	I		-		26. Place	of Death (1 □Yes Check only	one)	1 1 1	Yes 2	□No
hysic this ce if direc	To B	examiner? 1 ☐ Yes 2 No		ient 2 ☐ ER/		IT 3 LI DUA	ner: 4 □ Nu	ursing Home	5 ☐ Res	sidence 6	6 □Other	(Specify)	
ding P	ioi:	27. Manner of Death Natural 5 ☐ Pendir	28a. Date of Inj (Month, Da gation	ury ay, Year) 28	b. Time of Injury	Wor	ryat rk?]Yes 2□		d. Describe	how injury	y occurred		
Attender death	ificat	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of In	jury - At home	, farm, str	eet, factory, office	1163 2		. Location	(Street and	d Number o	or Rural F	Route Number,
tal or rs afte al Dire ed in b	Certification:	4 ☐ Homicide determ	building, e	tc.*(Specify)					City or 10	wn, State)	, 		
To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death. Fig. the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the b	edical	29a. Certifier (Check only one) Certifyli 2 Medical	ng Physician: To the best Examiner: On the basis and manner s	of examination	dg <i>e</i> , deat and/or in	h occurred at the t vestigation, in my	ime, date a opinion, dea	nd place, an ath occurred	d due to th at the time	e cause(s) e, date and	and mann place, and	er as stat	ted. ne cause(s)
To the within the complex comp	Me	29b. Signature and title of certifie	Tynz.	//		29c. Licens D44 Print)	se number			June	e signed (/	Month, Da	y, Year)
St		30. Name and address of person			a) (Type,	Print)	. , _	n	m char	- A	λη j	171	?
		Lafar N	Palik Mo	20	311	Coppan	s del	1302	2012/06	10 /	1 37 ~	-11/	

State Registrar

		For State Registrar		State of	f Mar	yland / [Depa <i>Cer</i>	rtmen tificat	t of H e of L	lealth Death	and N	lental Hy	gien Reg. N		109	1978
Physic /Medi		1. Decedent's Name	e (First, Midd	le, Last) ANNA M	IAE F	AULKN	ER					2. Date of D Month	D	Day 2009	Year	3. Time of Death 4:20 P
Exami				n, give street and nur		ER		4b. City,		Location		F	4	lc. County		CHESTER
Funeral Director		5. Social Security N 224-20-	umber			In yrs. last bir	thday) Yrs.	If Under Months		If Under Hours	_	8. Date of Bi (Month, D	rth a <i>y, Yea</i> 3/192		9. Birth	place (State or Foreign intry) VIRGINIA
the Maryland r 28a-f show notified at	ctor	Usual Residence of 10a. State MARYLAND	10b. County	ORCHESTER	1	0c. City, Tow	n or Loc	ation	C	CAMBE	RIDGE	3				10d. Inside City Limits 1 XYes 2 □ No
th with 23a of 1st be	ral Director	10e. Street and Nur		CEMETERY A	VE.			10f. Zip	Code	216	13		10g. C	Citizen of	What Cou	•
urs after deal al", or items Examiner mu	by Funeral	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed		If Yes Giv	rces? 2 ⊠ No ⁄e	er in U.S.		/as Deced Yes, spec □Yes		ispanic Or In, Mexica Specify		ecify Yes or N Rican, etc.)	0-		ck, White,	ican Indian, etc. WHITE
2 should be filed within 72 hours and Mental Hygiene. Is marked other than "natural", aumatic event, I've Medical Eva	Completed	(Spec	cify only highe	nt's Education st grade completed) College (1	-4or 5+)	16a	(Give I	O NOT us	rk done d se retired	during mos		ing	16b.	Kind of B		ndustry ACTURING
uld be filed wil Mental Hygien arked other th	To Be C	17. Father's Name		Last) CHARD TERF	RY ST	ROUP				18. Moth	er's Name	e (First, Middle SAR		en Surnan AN WI	,	
五章 2 章		19a. Informant's Na SANDRA La		ship <i>(Type. Print)</i> BARWICK / DA	AUGH		. Mailin	g Address	•			al Route Num. Γ., CAMB				
Pages 1 an ment of Heal ant: If item 2 ury or other		20a. Method of Disp 1 ☐ Burial 2 ☐ 4 ☐ Donation	Cremation	3 ☐ Removal from S		20b. Place o cemete MID SHO	ry, crem	atory or o	ther plac	· :		Date 5/2009	20c.		•	own, State
permit. Pa Departmer Important: any Injury once.		21. Signature of Fu	ineral 89 rvice	Licensee						s of Facili	*	TED 2272	HIDC	ON DD	CAM	DRIDGE MD 2161

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury)

23a. Part 1. Enter the disease, or shock, or heart failure. List

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)
JUN 19 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOMAN TOHANNY 503 RYRN

32. Registrar's Signature

Immediate Cause (Final disease or condition resulting in death)

_	End Stepe Dementiz Due to (or as a consequence of):	
	Arteriosc/erdhe cordibracaer ditease	
	Due to (or as a consequence ot):	
_	Due to (or as a consequence of):	

dica! Exan	that initiated events resulting in death) Last	Due to (or as a consequence of):	V-100-				
nysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 gronths? 1 □ Yes 2 DNo 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown				23d. Date of delivery Month Day Year		
5	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobac				\	co use contribute to the cause of death?		
Completed					24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of	
e D	25. Was case referred to medical examiner? 26. Place of Death (Check only				heck only one)			
0	1 Yes 2 DA	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: User Inpatient 2 ER/Outpatient 3 DOA Other: User Inpatient 5 Residence 6 Other (Specify)						
ertification:	27. Manner of D ath ☐ Ratural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury 28b. Ti		28d.	Describe how injury			
Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
edical	9a. Certifier (Check only one) (Check only one)							

29c. License number

SF

047924

CAMBRIDGE

29d. Date signed (Month, Day, Year)

6-15-25

MO

21613

Registrar

State

ORIGINAL

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State Registrar Registrar's Signature

Physician /Medical Examiner **Funeral** Significance Director th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Executor must be notified at Director Funeral Baltimore, Maryland 21215-0036 ð Completed barranous to Physician? 12 should be filed what and Mental Hygier is marked other th Be ပ permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any Injury or other trau **Physician** /Medical

Examiner certificate be exec physician a Box 68760, as attending asn for 1 P.O. signed by t Records, icate has been si page 2 should t certificate Division of Vital Hospital or Attending Physician: this After 1

death.

24 hours after death Funeral Director:

filled in by

completely

the To the within 7

14/11

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Florence Rhoda Grafton 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death VA Maryland Heath Care Se 5. Social Security Member 6. Sex 7. Age Perry Point Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day. In yrs. last birthday Year 1□ M 2X F 365-05-3337 June 30, 1917 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No Maryland Silver Spring Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1204 Windmill Lane U.S.A. 20905 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status VNYes 2 No fres, Give Year or Dates: 1943-45 1 Never Married 2 Married 1 □Yes XXNo Specify: Specify: 3√Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Stewarts Elementary/Secondary (0-12)
Twelve Years College (1-4or 5+) Assistant Buyer Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Dougherty Anna Lavonis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Leroy Grafton <u> 1204 Windmill Lane, Silver Spring, Maryland</u> 20b. Place of Disposition (Name of cemetery, crematory or other place)
Grove Presbyterian
Church Cemetery

22. Name and Address of Facility
Lee A. Patterson & Son Funeral Home, P.A. 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State Aberdeen, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 24 JVS Immediate Cause (Final disease or condition resulting in death) Intestin Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of). Physician/Medical yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 🎛 No Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy rmed? 2 No 1 ☐Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark D. Neuser, M.D., Yhmayyland
31. Date filed (Month, Day, Year)
32. Registrar's Signature Health Care System, Perry Point, MD 21902 0 8 2009 State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene ror State Registrar 6-8-09Amend#4a.PerPhys.PCCcr 1. Decedent's Name (First, Middle, Last) **Physician** Max Greenberg /Medical 4a. Facility Name (If not institution, give street and number) Examiner Residence 12 Wonder View Ct. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Director 027-07-3387 95 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County items 23a or 28a-f sh ner must be notified Directo Maryland Montgomery Gaithersburg 10e. Street and Number 12 Wonder View Court Funeral 12. Was Decedent Ever in U.S. 1 □ Never Married 2 X Married Baltimore, Maryland 21215-0036 ģ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) is marked other 17. Father's Name (First, Middle, Last) Be Isadore Greenberg 19a. Informant's Name/Relationship (Type. Print) item 27 is r other tra Harvey A. Greenberg - Son 20a. Method of Disposition Important: If it any injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Full eral Service License Part1. Enter the disease, or complications that caused the shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ONGESTIVE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? signed by the a d be detached for 9 Unknown þ Completed To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Yes 2 No 1 Inpatient ၉ this ours after death. neral Director: After this filled in by the funeral d 27. Manner of Death 28a Date of Injury 28h Time of Certification: (Month, Day Year) 5 Pending investigation

Certificate of Death 2. Date of Death Day Year Month May 24, 2009 4c. County of Death Gaithersburg Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Feb. 1, 1914 Massachusetts 10d. Inside City Limits 1 ☐ Yes 2 No 10f. Zin Code 10g. Citizen of What Country? 20878 United States 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 No Specify: Caucasian Specify: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Presser/Cutter Clothing 18. Mother's Name (First, Middle, Maiden Surname) Tilly Cohen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 Wonder View Court Gaithersburg, MD 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State King David Memorial Gardens May 27, 2009 Falls Church, VA 22. Name and Address of Facility Jefferson Funeral Chapel 5755 Castlewellan Drive Alexandria, VA 22315 ter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature ress of person who completed cause of death (Item 23a) (Type, Print) 15225 Shady Grove Rd. Rockville md. PLOTSKY JONATHAN MA 31. Date filed (Month, Day 32. Registrar's Signatu JUN 0 8 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar DHMH 17 Rev 1/2001

within 24 hours a

To the Funeral I

10

Medical

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Vear **Physician** P^{M} Louise K. Goldsmith 29 2009 2:20 Mav /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City Town, or Location of Death Examiner Bethesda Montgomery Suburban Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days 1 | M 2 | 3 | F Director 08/12/1919 Illinois 353-03-1261 Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the "fadical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Fairfax Annandale Vа 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Funeral 4303 Wynnwood Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 □ No Specify: Specify: White ð 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Education School Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be finance and Mental F Dorothy Block Robert Kramer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit, Pages 1 and 2 st Department of Health and Important; If item 27 is n any injury or other traum 4303 Wynnwood Dr., Annandale, Virginia 22003 Dr. Arthur Goldsmith, husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 05/31/09 Alexandria, Va. Home of Peace Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Jefferson Funeral Chapel 21. Signature of Funeral Service Licenses 5755 Castlewellan Dr., Alex, Va. 22315 15. I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest thock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Pheumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Class of injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit Due to (or as a consequence of) Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? 1 ☐ Yes 2 ☒No Month Dav Year 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate Vital 1 □Yes 2 □ No 9 Hospital or Attending Physician: 24 hours after death. 9 Funeral Director: After this certifica etely filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA oţ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier May 29, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 8600 Old Georgetown Rd., Bethesda, Md. MDSujoy Tagore, 31. Date filed (Month, Day, Year JUN 0 8 2009 State Registrar

09-04317 Philip Joseph Ga	lipe	Please Type	or Print in Blace of Maryland / D	k Indeli	ble Ink. Er	nsure All (Copies Are	e Legik	ole.	109 1979
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Physicia	n/	 Decedent's Name (First, Middle,La 	•				Mont			3. Time of Death
Medical Examin		Philip Josep			4b. City, T	own, or Location		30, 2009	4c. County of De	eath
		2561 Paddock Drive	,		David	sonville			Anne Aruno	
Funeral Director		5. Social Security Number 6. s 15	Sex 7. Age (II	n yrs. last birtl 2	Months			e of Birth(N	IFO	Birthplace (State or reign Massachusetts Country)
ý	- 1	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town	or Location					10d. Inside City Limits
d now any .e.		Maryland Anne An		, ,	avidsonv	ille				1 Yes 2 X No
vith the Maryland 5 23a or 28a-f show 1 notified at once.		10e. Street and Number			10f. Zip			10g.	Citizen of What (Country?
the M 3a or 2	ă	2561 Paddock Dr	ive			035			USA	
th with ems 2.	eral	11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent Even	er in U.S.	13. Was Decede If Yes, specif	nt of Hispanic Or y Cuban, M exica	igin? (Specify Ye n, Puerto Rican, e	etc.)	14. Race - A White, et	merican Indian, Black, c.
er dea	F		1 X Yes 2 ed If Yes, Give Year 197	1 - 73	1 Yes 2	X No specify	<i>r</i> .		Specify: W	Mhite
ours afi utural'	a P	15. Decedent's Education (Specify	or Dates:	eted) 16a.	Decedent's Usual during most of wor	Occupation (Give	e kind of work dor	e 16	b. Kind of Busin	ess/Industry
6 172 ho an "ns ical Ex	ete	Elementary/Secondary (0-12)	College (1-4 or 5+)		Oral Sur	-	r ase rearea)		Dentis	strv
OO3	Completed by Funeral	17. Father's Name (First, Middle, La	5+ years		- Oral Dai		er's Name (First, I	Middle, Mai		
215 se filec stal Hy sked of	a B		e Galipeau					en Co		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	흔	19a. Informant's Name/Relationship		19	b. Mailing Address	(Street and Nu	mber or Rural Rov. Potom	oute Numbe ac. M	er, City or Town, S [arvland	State, Zip Code) 20854
, ME and 2 s ealth a em 27		Greg B. Galipea 20a. Method of Disposition	u/ 3011		of Disposition (Nar	ne of cemetery,	Date			ty or Town, State
lore ges 1 g nt of H nt of H other 1		1 Burial 2 X Cremation		li .	tory or other place; s Cremat		6/1/09		Edgewat	er, MD
altim nit. Pa artmer sortani		4 Donation 5 Other Spec 21. Signature of Funeral Service Lice	fy: ensee	1	22. Name and	Address of Facil	ity George	Р. К	alas Fu	neral Home
Dep Der In in ju		What I'lled	12		2973 5	Solomons	Island	Rd. E	dgewate:	r, MD 21037
Physician 'Medical		23a. Part I. Enter the disease, or confailure. List only one cause on	each line.		ot enter the mode	of dying, such as	cardiac or respir	atory arrest	, snock, or neart	Between Onset and Death
aminer		Immediate Cause (Final disease or condition resulting in death)	a. Cirrhosis of live							
		Sequentially list conditions,	b							
	xaminer	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequ	uence of):						
- ·=		(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	uence of):						
(ecuted	ia E		d							
30, ie be er ysiciar burial	ledic	UNPENDED IF FEMALE:	23c. If yes, outcome	of pregnancy					23d. Date of de	elivery
Box 68760, e death certificate by the attending physiced for use as the bur	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	1 Live birth		2 Fetal death		pic pregnancy		Month	Day Year
OX (eath co	/sici	1 Yes 2 No 9 Unkno	4 Pregnant at tir	ne or death	5 Other (Spe	ecify)			1	1
P.O. B so that the d gned by the		Part II. Other significant condition	s contributing to death b	out not resulting	ng in the underlyin	g cause given in				te to the cause of death?
ires th	ed by							1 Yes 4a. Was ar		Probably 4 Unknown ere autopsy findings available
ords w requas beer	ompleted							autops perforn	y pri	or to completion of cause of ath?
Rec The la icate h	Com							✔ Yes 2		Yes 2 No
ital ician:	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient	2 FR/0	Outpatient 3	26.Place of Dea	th (Check only or Nursing Hom		Residence 6	Other: Scene
of Vi	6	1 Yes 2 No 27. Manner of Death	28a, Date of Injury	/ 28b	. Time of Injury	28c. Injury at W			ow injury occurre	d
OD C ending sath. or: Af the fun	tion	1 Natural 5 Pendin		ar)		1 Yes 2				
Division of Vital Records, tat or Attending Physician: The law requir rs after death. "I Director: After this certificate has been seled in by the funeral director, page 2 should lead in by the funeral director.	Certification:	2 Accident Investign 3 Suicide 6 Could be	not be 28e. Place of Inju	ry - At home,	farm, street, factor	y, office building		ocation (Stor Town, St		or Rural Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans		4 Homicide 29a. Certifier 1 Continue Physical Physics	ined (Specify) sician: To the best of my	lemanula de e d	anth acquired of the	no time, data and	nlace, and due to	the cause	(s) and manner	as stated.
To the Ho within 24 To the Fu	Medical	(Check only one) 2 Medical Exam	ner:On the basis of exami	knowledge, di ination and/or	eath occurred at the investigation, in n	ny opinion, death	occurred at the t	ime, date a	ind place, and du	e to the cause(s)
To To	Jec	29h. Signature and title of certifier	and manner stated.			9c. License numb				d (Month, Day, Year)

Margarita Korell MD. State 31. Date filed (Month, Day, Year)
Registrar JUN 0 2 2009

30. Name and address of person who completed cause of death (item 23a)

Assistant Medical Examiner

Sall

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

May 31, 2009

OUNE

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician VIRGINIA ELIZABETH GULICK lune /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or bocation of Death Examiner 19 ENTER 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 🔀 F 577-05-5475 92 Director FEB.14,1917 Usual Residence of Decedent 21032 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. In the Company of them 23a or 28a-f show Important: I frem 7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Examination nother than the profitted at Director MD CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11080 WEYMOUTH COURT 20603 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2∑ No ۇ م Specify. Specify: 3 □ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER AT HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM RIVES MILLER ELIZABETH GERTRUDE BLANFORD 9 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA GREGORY/DAUGHTER RAINBOW DR. #11193 LIVINGSTON. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) VETERANS CEM 22,2009 21. Signature of Funeral Service Licenses -12y M00641 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 21tive disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Duc to for as a consequence of and resulting in death) Last Due to (or as a consequence of) physician a Box 68760. g Physician/Medical The law requires that the death certificate attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 pronths?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a o 9 Unknown 9 Unknow ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ Completed peen 24a. Was an has autopsy performed? Yes 2 No certificate 1 □Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Division 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. after death

Director: A in by the f 2 Accident 6 □Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 29a, Certifier 🔼 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner, On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

CHELTENHAM, MD 22. Name and Address of Facility RAYMOND FUNL, SERVICE, P.A. 5635 WASHINGTON AVE., LA PLATA, MD 20646 Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PoBox 2665 LaPlata, Md. 20646 a Grange Ave **ORIGINAL**

2009

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WHITE

TX

77399

Birthplace (State or Foreign Country)

WASHINGTON, DC

10d. Inside City Limits

1 ☐ Yes 2 XNo

State Registrar

31. Date filed (Month, Day,

JenKINS

32. Registras Signature

			Please	Type or Prin					_		_	
			for State Registrar	State of Ma	aryianu		rtificate of			Reg. No	2000	19792
			Decedent's Name (First, Middle, L.	ast)			-	-	2. Date of De			3. Time of Death
٠,.	Physici: Medic/		Frances	B. Henslev					Mav 27	, 20	09	12:20 PM
	Examin	er	4a. Facility Name (If not institution, gr	ive street and number)			4b. City, Town, or Annar	r Location of Deat	h		. County of Deatl nne Arur	
- F	uneral				e (In yrs. las	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	rth	9. Birti	hplace (State or Foreign
	irector		239-05-2031	1□M 2¶F	96	Yrs.	Months Days	Hours Min.	Jan.8,	191	3 Nort	ch Carolina
land	wo II		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
Mary	a-f sh	ctor	Marvland Anne Ar	undel		Annap	olis					1 No Yes 2 No
ith the	or 28	Director	10e. Street and Number				10f. Zip Code			-	tizen of What Co	-
ath w	s 23a	eral	703 Dreams Landin		Everin II C	10.1		. 401	Specify Ven or No		ited Sta	
ter de	r item inc	Funeral	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent 8 Armed Forces? 1 \(\text{Yes} \) 2 \(\text{T} \) 1 \(\text{Yes} \), Give \(\text{A} \)			Was Decedent of H If Yes, specify Cuba	an, Mexican, Puerl	to Rican, etc.))-	Black, White	
OUSO	ral", o Exen	b	3 Widowed 4 □ Divorced	if Yes, GiveΛ Year or Dates:			1 □ Yes 2 □XNo	Specify:			Specify: Wh	nite
at yiallid ZIZI3-0030 should be filed within 72 hours after death with the Maryland	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "hocical Examinat" aust be radified at once.	Completed	15. Decedent's E (Specify only highest g	ducation rade completed)		(Give	dent's Usual Occup	during most of wor	rking	16b. k	(ind of Business/I	ndustry
withir	than the M	dwo	Elementary/Secondary (0-12)	College (1-4or 5	+)		DO NOT use retired Secretary	•		Co	untv Gov	vernment
t be filed	other vent,	BeC	17. Father's Name (First, Middle, Las	t)				18. Mother's Nar	ne (First, Middle	, Maider	n Surname)	
y a	arked atic e	2	Hilliard Dani	el Ballard				Flora	A. Hill			
Vidi 12 sh	7 is m traum		19a. Informant's Name/Relationship				ng Address (Street					
1 and	tem 2 other		Gayle Henslev / I 20a. Method of Disposition	Jaughter	20b. Pla	ce of Dispo	reams Lar	i	Date Date		ocation - City or	
mit. Pages	nt: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	Removal from State	L .	-	natory`or other plac Cremator	· i)/09	Ba1t	imore, N	Marvland
mit.	Importa any inju once		21. Signature of Funeral Service Lice		Dare		2. Name and Addre					
0 8 č	돌돌됨		Myslin T.	When		1	47 Duke o	of Glouce	ester St	An		<u>MD 21401</u>
			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused one cause on each lin	the death. ne.	Do not ent	er the mode of dyir	ng, such as cardia	c or respiratory a	arrest,		Approximate Interval Between Onset and Death
	sician edical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as			tion					
Exa	miner				a conseque	nice oi).						
p	##	iner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	Due to (or as a	a conseque	nce of):						
be executed	sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a	a conseque	nce of):				<u> </u>		
	sician buria			_d	a bombeque	1100 017.						
Attending Physician: The law requires that the death certificate reach.	attending physic	Physician/Medical										
ath ce	ttendii or use	an/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome a 1 ☐ Live birth			☐ Ectopic pregnanc	у		1	23d. Date of del Month	ivery Day Year
be de	the a	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	t time of dea	ath 5□	Other (specify) _				MONET	Day Tou.
that t	signed by the		Part II. Other significant conditions	contributing to death bu	ut not resulti	ing in the ur	nderlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
quires	s been sig	ed by							1 🗆	Yes 2	No 3□ Pr	obably 4 ☐ Unknown
law re	2 sho	Completed							24a. Was		24b. Were au	topsy findings available completion of cause of
e :	cteh , rage	Con							perfo 1 □ Yes	ormed? 2 D N	death? 1 ☐ Yes	2 🗆 No
sician	r this certificate has braid director, page 2 st	Be	25. Was case referred to medical examiner?	Hospital:			Oth	26. Place of Dea				
P Phy	er this eral di	n: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injur	ry 2	8b. Time of	IL 3 LI DOA	4 KD Nursing r	lome 5 ☐ Res 28d. Describe		6 □Other (Speciary occurred	cify)
ath.	r: Aff	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	1	y, Year)	Injury		<br Yes 2 □ No				
or Atte	irecto n by th	Certification:	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined		ury - At hom c. (Specify)	e, farm, str	eet, factory, office		28f. Location (City or To	Street a wn, Stat	nd Number or Ru e)	ıral Route Number,
pital o	filled		29a. Certifier 1 Certifying P	hysician: To the best of	of my knowl	ladra dastl	h accurred at the til	ma data and plac	e and due to the	a causal	s) and manner as	stated
n 24 h	To the Funeral Director; After th completely filled in by the funeral	edical		miner: On the basis of and manner sta	f examinatio							
To the	To the	ğ	29b. Signature and title of certifier	. 25			29c. Licens	e number		29d. Da	ate signed (Monti	h, Day, Year)
)			11/1/12	5			D3	32036		Ma	ıy 28, 20	009
412	١		30. Name and address of perso who	,	•		,	3.6	1 - 1 0	1610		
XX.	Stat	te	Gary Sprouse, M.I. 31. Date filed (Month Pay, Year)	2108 D1	uonat ar's Signatu	o Dri	ve, Chest	er, Mary	riand 2	1016		
	Registra	ar	JUN U 3 2	2009 32. legistra	n p	1. 1.	aks					

DHMH 17 Rev 1/2001

State Registrar filed (Month

			For State Registrar	Pleas	se Type or State			d / Dep		nt of H	lealth and			_egible.	
İ	Physicia /Medic		1. Decedent's Name Samuel H		,							2. Date of D Month June	eath Day	Year 2009	3. Time of Death 1 23:37 M
	Examin		4a. Facility Name (If Southern 5. Social Security Nu	Maryla	nd Hospi	tal	e (In yrs. la	ast birthday	Cli	nton r 1 Year	Location of Dea	8 Date of B	Pr	ince Ge	
	Director		249-66-82 Usual Residence of		1⊠M 2□ F	<u></u>	6 10c. City,	6 Yrs.	Months	Days	Hours Min	07/24			SC 10d. Inside City Limits
	h the Maryl or 28a-f sho	Director	NC 10e. Street and Num	Harne	tt		Li1	lingt		p Code			10g. Citiz	zen of What Co	1 X Yes 2 □ No ountry?
136	i within 72 hours after death with the Maryland ijene r than "natural", or items 23a or 28a-f show the Medical Evaning rule be notified a	by Funeral I	1303 Erne 11. Marital Status 1 Never Marrie 3 Widowed	ed 2🛛 Marri	12. Was De	Forces? 3 2 📆 I Give		6. 13			lispanic Origin? (: an, Mexican, Puel Specify:	Specify Yes or Note Rican, etc.)		USA 14. Race - Ame Black, White Specify: B	e, etc.
1215-0036	filed within 72 hou Hygiene. other than "natura ent, the Medical E	Completed	(Speci	15. Decedent ify only highes		d)	5+)	(Giv life.	edent's Usi e kind of w DO NOT (ork done ise retired	durina most of wo	rking	Ï	ic Scho	•
land z	il Hyg othe vent,	To Be Co	12 17. Father's Name (A		Last)			Ouse	Odlar		18. Mother's Na		le, Maiden S	Surname)	,
e, Mary	and 2 shou fealth and N m 27 is ma her trauma		19a. Informant's Na	e Hammo		2		1303	Erne	st B	and Number or Fi	, Lilli	ngton	, NC 27	7546
Baltimore, Maryland 2	permit. Pages 1 and 2 should be Department of Heatth and Menta Important: If item 27 is marked any injury or other traumatic enone.		20a. Method of Disp 1 ⊠ Burial 2 □ 4 □ Donation 21. Signature of Fur	Cremation 5 Other (Sp	<u> </u>	n State	- 1	thave				Date 07/2009 cricklar	Dunn	cation - City or neral Sc	
ou,	eath certificate be executed attending physician and for use as the buriat-transit	dical Examiner	23a. Pa : Enter the shock, or hear Immediate Cause (I disease or condition resulting in death) Sequential (Is to if any, leading to immediate Cause (Disease or it that intitated events resulting in death) L	rt fallure. List of Final of the second of t	a. Due t	o (or as		ence of):	nter the mo	de of dyir	town Rd.	c or respiratory	arrest,		Approximate Interval Between
ă	the death certificate by the attending phys Iched for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 r 1 □ Yes 2 □ 9 □ Unknown	months?		e birth egnant a	of pregnar 2 ☐Fetal It time of de	death 3	□ Ectopic □ Other (s		y			23d. Date of de Month	livery Day Year
ecoras, P.	requires that the een signed by th nould be detache	by	Part II. Other signifi	Cant condition	ns contributing to	death b	ut not resul	Iting in the	underlying	cause giv	en in Part I.		tobacco u		o the cause of death? robably 4 ➤ Unknown
Hec Hec	n; The law i ificate has b or, page 2 sh	Completed	25. Was case referr	ad to medical								pei 1 □ Yes	opsy formed? 2 No	prior to death?	utopsy findings available completion of cause of
0	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Certification: To Be	examiner? 1 Yes 2 27. Manner of Death Natural 2 Accident	No 1 5 □ Pendinq investig	28a. Da (<i>M</i>	Inpation		R/Outpati 28b. Time Injury	ent 3 □ D	28c. Injui Wor	er: 4 🗆 Nursing	eath (Check only Home 5 Re 28d. Describ	sidence 6		ecity)
DIVISION	oital or Atte urs after dea ral Directo illed in by th		3 ☐ Suicide 4 ☐ Homicide	6 Could r determi	ned 28e. Pla	lding, et	ury - At hor c. (Specify	<i>')</i>				City or T	own, State,) 	ural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical		2☐ Medical			of examinat		investigatio	n, in my o			e, date and		e to the cause(s)
	10	7	30. Name and address	ess of person	who convileted of	use of c	death (Item	23a) (Type	e, Print)	7 V	3838	400	207	25	- 1 12
	Sta Registr		31. Date filed (Monta	h, Day, Year) 2009	11111	Regist	ar's Sign to	ure	12 1			,11161	au 1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death 2009 Year Month **Physician** Dorothy Jean Hunger 3 11:55a M June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Transitions Health Care Sykesville Carrol1 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ XF Yrs 234-32-1227 Director Oct 31 1924 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ital Modical Examinations to nother traumatic event, Ital Modical Examinations and injury or other traumatic event, Ital Modical Examinations and injury or other traumatic event, Ital Modical Examinations. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Carrol1 Sykesville 1 ☐Yes 2 XNo **Funeral Director** 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 7309 Second Avenue 21784 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 ☑ No Specify: Completed by Specify: white 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) food service waitress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bernard Brannon Grace Freeman ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6155 Deanna Dr., Sykesville, MD 21784 Stephen L. Perrine (son) Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State All County Cremation 6-5-09 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Parge Harght e has a nate P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Clostno **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 □Yes ÆM No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 □ Natural 2 □ Accident 5 Pending o the Hospital or Attendir ithin 24 hours after death. o the Funeral Director: A death. investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D43725 6/3/09 WIL 21144 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

19

32. Registrar's Signature

MALTMUOD

31. Date filed (Month, Day, Year)

Road

Westminister

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 7 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Mav 29, Year **Physician** 2009 2:10 P M Janet Movle Harryman /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Tate Hospice House Linthicum If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Dec. 21,1925 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1□ M 2 F Dec. Pennsylvania 83 199-14-7783 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Examinar many 2000. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☑ No **Funeral Director** Marvland Anne Arundel Annapolis 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21409 United States 945 Aqua Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ▼ No 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates ξ 3 Widowed 4 Divorced White Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Federal Government Administrator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Peter Movle Annie Grace Jenkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2408 Erdman Avenue, Baltimore, MD 21213 Brian Harryman / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory : 6/1/09 Baltimore. Marvland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Forey 6 months Canu /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by Division of Vital Records, Diabetes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed/ 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) MUUSE 1 | Yes 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1252830 (anine Weiner, MY) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO 900 Bestage Rued #300

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 20013 28,2009 bie 05 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Anne Arundel 6 Fisk Circle Annapolis If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** Date of Birth (Month, Day, Year) Months Days Hours 1 □ M 2 🔀 F Director 579-38-5519 85 Dec. 16,1923 Virginia Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County la or 28a-f show t be notified at 1 ☐Yes 2 ☐ No Directo Marvland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Fisk Circle 21401 United States ral", or items 23a Examiner must b Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 □WNo Specify: Specify. 3 ☑ Widowed 4 ☐ Divorced White 'natural", er than "natura , If a Madical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene. 27 is marked other than " r traumatic event, It a Ma Elementary/Secondary (0-12) College (1-4or 5+) Business Woman Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Earl Carson Fannie Wright ပ of Health and Nitem 27 is mail 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Haberlein / Daughter 2 Fisk Circle, Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages
Department of I
Important; If its
any injury or o o N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemeterv 6/2/09 Brentwood, Marvland 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licensee Mylin 147 Duke of Gloucester Street, Annapolis. MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): year /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mor 1 ☐ Yes 2 ☐ No Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>۾</u> 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ ₩0 funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 24 hours a 29a. Certifier 1 vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. the

31. Date filed (Month, Day, Year)

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30. Name and address of purson who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

32. Registrar's Signature

vite

5

DHMH 17 Rev 1/2001

Registrar

29c. License number

29d. Date signed (Month, Day, Year)

29,2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Ma RICA Hal /Medical County of Death 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death Examiner HUUL GI Burn Ghen Washington Med Che Saltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Apr 12 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex P. Age (In yrs. last birthday) **Funeral** ^{Year)} 973 1 □ M 2√2 F Months Days Hours Min Maryland 214-90-2442 36 Yrs. Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, it a Medical Examiner must be retified at 1 ☐ Yes 2 No Directo Pasadena Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21122 IISA 371 Harlem Ave Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after Never Married 2☐ Married If Yes, Give Year or Dates: 1 □Yes 2√□No Specify. Specify: Black <u>ک</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) First Lady's Elementary/Secondary (0-12) Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, If a Mone. College (1-4or 5+) 12th 0 Beautician Beauty Salon 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Patricia Ann Turner Wade Hall Sr. ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pasadena, 21122 Md. Patricia Hall (Mother) Harlem Ave 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 6/3/09 Annapolis, Md. Bestgate Mem. Park Windame Redese of & cilisons Mortuary, P.A. 21. Signature of Funeral Service Licensee West St. Annapolis, Md. 821 23a. Part 1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Mese MCO783 Approximate Interval Between Onset and Death ancen Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-trans Due to (or as a consequence of): sate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 2 No 1 ☐ Yes 1 ☐ Yes nours after death.

neral Director: After this certificat
v filled in by the funeral director, ps Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1' Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Deuth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation T Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one)

Hospital or Attending Physician: The law requires that the death certificate be execut Division of Vital Records, P.O. Box 68760, To the

Baltimore, Maryland 21215-0036

State Registrar

OYA

d title

29d. Date signed (Month, Day, Year)

M

of death (Item 23a) (Type, Pr. 30. Name and address

301

Year) 31. Date filed (Month, Day,

29b. Signature a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Edward Holahan June 11.05 Am 0 2009 /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE MARYLAND JOHNS HOPKINS BAYVIEW If Under 1 Year | If Under 24 Hrs 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**X** M 2 □ F 51 213-82-8648 Director May 1, 1958 Washington DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time ZY is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, Ite Martical Examinations. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State Frederick Maryland Frederick 1 X Yes 2 No Director 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? 510 Logan Street 21701 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade com 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Editor News Print Media 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gordon V. Holahan Mary Gorman ౖ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 510 Logan Street, Frederick, Maryland 21701 Janet Lilly / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State June 16, 2009 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory Smithsburg, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service License Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, Maryland 21701 M01433 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiovespiratory /Medical Due to (or as a consequence of): Examiner Much organ sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine -transit Area Deep burn. The law requires that the death certificate be executed and burialattending physician for use as the buria Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting i Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No Division of Vital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 √Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Self Inflicted investigation June 10hi, 2009 1 ☐ Yes 2 ☐ No 2 Accident 1.20 Am 3 17 Suicide 6 ☐ Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State)
510 Logan St. Fredenck MD 2 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal

within 24 hours after death.

To the Funeral Director: # filled in by the To the Hospital

> State Registrar

(Check only one)

29b. Signature and title of certifier

4940 BISWAS EASTERN 31. Date filed (Month, Day, Year)

ptarshi Bisuns, Md, FRCS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrat's Signature Clever

DIL

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

AF 2664200

AVENUE BACTIMORE, IND 21224

29d. Date signed (Month, Day, Year)

2009

09-04460 Derric A. Jackso	n	Please Type State	or Print in Black e of Maryland / De	epartment of	Health and Men	Copies Are L tal Hygiene	egible.	2000	10001
		1- For State Registrar		Certificate of	Death		Reg. No.	4003	19801
Physicia Medical Exami		Decedent's Name (First, Middle,Li	ast)			2. Date of Do Month June 4,	Day	Year	3. Time of Death 1315 hrs
Wiedical Examin	iei	DERRIC A. JACKS 4a. Facility Name (if not institution, g		1	1b. City, Town, or Location			unty of Death	
re-of		9891 Good Luck Road A			Lanham			ce George's	
Funeral		Social Security Number 6.	Sex 7. Age (In y	rs. last birthday)			Birth(MM/DD/	YYYY) 9. Birth	achington
Director		579-94-0243	X M 2 F	39 Yrs		7/25/	1969_	Cour	DC_
any		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Locati	on			1	I0d. Inside City Limits
d how a			Coorsola	anham					1 X Yes 2 No
arylan arylan at onc	Director	Maryland Prince 10e. Street and Number	George S L	anham	10f. Zip Code		10g. Citizen	of What Countr	у?
the M a or 2	Ö	9891 Good Luck R	oad #10		20706		United	States	3
ms 23	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13. Wa	s Decedent of Hispanic Ones, specify Cuban, Mexican	gin? (Specify Yes or n. Puerto Rican, etc.)	No- 14.	Race - America White, etc.	an Indian, Black,
r death	Fun	1 Never Married 2 X Marri	1 Yes 2 X Ned If Yes, Give Year				Sne	ecify: Blacl	
ırs afte tural", imine	þ	3 Widowed 4 Divorc 15. Decedent's Education (Specify	or Dates:	ed) 16a. Deceder	t's Usual Occupation (Give	kind of work done		of Business/In	
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215-0036 be filed within 7 tatal Hygiene. ked other than ent, the Medica	dm	12		Cement	Mason			vate	
15-C		17. Father's Name (First, Middle, La	st)			r's Name (First, Middl		name)	
212 uld be Menta marko c even	To Be	Arthur Jackson 19a. Informant's Name/Relationship	(Type, Print)	19b. Mailin	Address (Street and Nur	erne Spenomber or Rural Route		r Town, State,	Zip Code)
MD nd 2 sho alth and m 27 is aumatic		Shelle Jackson /	Wife	9891	Good Luck Rd		nam, Ma	ryland	20706
re, l s 1 and f Healt f item er tra		Shelle Jackson / Wife 9891 Good Luck Rd. #10 Lanham,							own, State
Pages Pages ant: 1		4 Donation 5 Other Spec	ify:	incoln Me	emorial	6/16/2009	Suit	land, l	Maryland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland bepartment of Handla and Mental Hygiene. In profram: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	ensee	22. 1	Name and Address of Facilit	Pope Fune:	ral Hom	nes, P.	A.
Physician		23a. Pair I. Enter the disease, or co	mplications that caused the d	leath. Do not enter t	88 Marlboro P he mode of dying, such as	oardiac or respiratory	tville, arrest, shock,	Mary Lor heart	Approximate Interval
/Medical		failure. List only one cause on	each line. a. Cocaine int						Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a consequer						
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	miner	if any, leading to immediate course. Enter Underlying Course (Disease or injury that initiated	C						
ed nsit	Exal	events resulting in death) Last	Due to (or as a consequer	nce of):					
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transi	cal	XUNPENDED	d. AMENDED 23a,2	7,28a-f,p	erME, g892 6	/23/09 TT			
60, ate be a hysicia	an/Medical	IF FEMALE:	23c. If yes, outcome of	pregnancy	-		23d. D	ate of delivery	
687 ertific iding p	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at time	of dooth		ic pregnancy	Mo	onth Da	ay Year
Box 68760, e death certificate be the attending physical for use as the but	ysici	1 Yes 2 No 9 Unkno		or death 5 O	ther (Specify)				
Records, P.O. Box 68760, The law requires that the death certificate be cate has been signed by the attending physici page 2 should be detached for use as the buri	/ Phy	Part II. Other significant condition	s contributing to death but	not resulting in the	underlying cause given in P				he cause of death?
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of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by uneral director, page 2 should be detach	5	1 ✓ Yes 2 No 27. Manner of Death	Inpatient 28a. Date of Injury	2 ER/Outpatien 28b. Time of	. 0	Nursing Home 5	Residence be how injury	occurred	Scene
on o nding th. :: Afte	ion:	1 Natural 5 Pendin	(Month, Day, Year)	Fd 12:	1 Van 2X		,,		
Division tall or Attending as after death. The Director: A led in by the fu	ertification:	2 Accident Investig	28e. Place of Injury	At home, farm, stre	et, factory, office building, e	etc. 28f. Locatio	n (Street and	Number or Rur	al Route Number, City
Divis	ertii	3 Suicide 6 A Could r 4 Homicide		esidence		Apt	0 Lanh	am, MD	Luck Ku
Division of Vital I o the Hospital or Attending Physician: within 24 hours after deals in the Funeral Director: After this certifi ompletely filled in by the funeral director,	SalC	29a. Certifier 1 Certifying Physics (Check only	sician: To the best of my kno	owledge, death occu	irred at the time, date and p	lace, and due to the d	ause(s) and n	nanner as state	d. cause(s)
Foth within compl	edical	one) 2 Medical Exami	ner: On the basis of examination and manner stated.	uon and/or investiga	ation, in my opinion, death o	eu at the time, d		to signed (Mar	

State 31. Date filed (Month, Day, Year) JUN 1 6 2009

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Melissa Brassell, MD

Registrar

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

June 5, 2009

09-04324 Christopher Jones Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hydiene

ristopher Jones	1-	State of Maryland / Department of Certificate of Ce		Reg. No.	2009 1990
Physician		egistrar Decedent's Name (First, Middle,Last)		2. Date of Death Month Day May 30, 2009	3. Time of Death Year 1820 hrs
edical Examine	er	Christopher Jones	4b. City, Town, or Location of Deat		County of Death
	4	Facility Name (if not institution, give street and number) Baltimpre Washington Medical Center	Glen Burnie	·· A	Anne Arundel
Funeral	5	Social Security Number 6. Sex 7. Age (In yrs. last birthday)		_	/DD/YYYY) 9. Birthplace (State or Foreign Country)
Director		214-43-2777 1XM 2 F 14	Yrs. Months Days Hours Min	n. 10/27/19	94 Maryland
b	_	Isual Residence of Decedent Oa. State 10b. County 10c. City, Town or Loc	cation		10d. Inside City Limits
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Aaryland 28a-f show		Maryland Anne Arundel Cro	10f. Zip Code	10g. Cit	izen of What Country?
th the Maryland 23a or 28a-f sho notified at once.	2	2412 Old Mystic Ct.	21114		USA
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	= 1	Armed Forence	Was Decedent of Hispanic Origin? (\$ If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
or death	티	1 Yes 2 X No	Yes 2 X No specify:		Specify: White
irs afte	<u></u>	or Dates:	dent's Usual Occupation (Give kind or g most of working life. DO NOT use re		Kind of Business/Industry
72 hou n "nai	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)			Education
within jene.	틹	9th 17. Father's Name (First, Middle, Last)	Student 18.Mother's Nar	ne (First, Middle, Maider	
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than event, the Media	ŭ B B	David I. Jones		Jennifer S	Sue Lenox
212 ould by d Ment s mark	ᆰ	19a. Informant's Name/Relationship (Type, Print)	ailing Address (Street and Number of		
MD nd 2 sho lith and m 27 is aumati			70 Happy Lane, Cr	Date 20c	Location - City or Town, State
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical	- 1	4 X Puriol 3 Compation 3 Removal from State crematory o	or other place)	/3/09 W	est River, MD
Baltimore, permit. Pages I an Department of He Important: If ite	-	4 Donation 5 Other Specify:			alas Funeral Home
Ba perm Depa Impo	-		2973 Solomons Is	land Rd. Ed	dgewater, MD 21037
Physician	7	23a. Part i. Enter the disease, or complications that caused the death. Do not entifailure. List only one cause on each line.	ter the mode of dying, such as cardia	c or respiratory arrest, s	Between Onset and Death
'Medical aminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			
		Sequentially list conditions,			
	ie.	if any, leading to immediate Due to (or as a consequence of):			
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
iO, e be executed ysician and burial - transit		d			
O, e be ex ysician burial	edical	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
876 rtiffcati ing phy	an/M	23b. Was decedent pregnant in the 1 Live birth 2	Fetal death 3 Ectopic pre	egnancy	Month Day Year
Box 6876 e death certificate the attending phy ed for use as the l	Physician/M	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)		
D. B at the de by the		Part II. Dther significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		co use contribute to the cause of death? 2 No 3 Probably 4 Unknown
P.O.	d by			1 Yes 2	24b. Were autopsy findings available
rds v requi	Completed			autopsy performer	prior to completion of cause of
Reco	mo			1 ✓ Yes 2	No 1 ✓ Yes 2 No
Vital Records, sysician: The law requilible certificate has been director, page 2 should	Be C	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ✔ ER/Output	26.Place of Death (Ch atient 3 DOA Other; No		sidence 6 Other:
f Vil Physic er this	70	1 Yes 2 No	ne of Injury 28c. Injury at Work?	28d Describe how	injury occurred Ited and fell off bicycle
on of Inding Phon. T: After the funeral	tion:	1 Natural 5 Pending May 30, 2009 and 1615 h	ırs 1 Yes 2 ✔ No)	
Division of Vital Records, ral or attending Physician: The law require its after death. In Director: After this certificate has been signed in by the funeral director, page 2 should be the funeral director, page 2 should be the funeral director.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm	, street, factory, office building, etc.	or Town State	et and Number or Rural Route Number, City
Di spital nours a neral I	Cert	4 Homicide determined (Specify) Local Street	and at the time date and place		Drive, Crofton, MD
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation.	occurred at the time, date and place, estigation, in my opinion, death occur	red at the time, date and	d place, and due to the cause(s)
To	Med	and manner stated. 29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Month, Day, Year)
		Carol Hallan	O.C.M.E.		May 31, 2009
N,O		30. Name and address of person who completed cause of death (Item 23a)	enn Street, Baltimore, MD 2	1201	
· W		Calibration, the	,		
S Regis	tate trai	31. Date filed (Month, Pay Year 2 2009 32. Registrar's Signature	park		

ORIGINAL

09-04308 William Kelly, Jr.

Meg

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Trends.	1	100	400	ě.	and .	U	1

alli Nelly, Ji		1- For State Certificate of L		Reg. N	40. ZU	09 1980
Physici		Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death
ical Exami				Month Da May 30, 2009	y Year	0740 hrs
		4a. Facility Name (if not institution, give street and number) 4b.	City, Town, or Location of Death		4c. County of Dea	1
		103 Hickory Lane	Annapolis		Anne Arunde	
Funeral		Social Security Number	If Under 1 Year If Under 24Hrs		MM/DD/YYYY) 9. B	irthplace (State or
Director		218-32-6594 TXXM 2 F 74 Yrs.	Months Days Hours Min	Dec. 8,	1934	ountry) Maryland
	l	Usual Residence of Decedent				
any.		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
d how	_	Maryland Anne Arundel	Annapolis			1 Yes 2 XNo
daryland 28a-f show dat once,	ts	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Co	
ith the Maryland 23a or 28a-f sho notified at once.	Director	103 Hickory Lane	21403		U.S.	Α.
vith th s 23a e noti	- m	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	Decedent of Hispanic Ongin? (S	pecify Yes or No-		erican Indian, Black,
eath v item ust b	uneral	1 Never Married 2 XX Married Armed Forces? If Yes 1 X Yes 2 No	s, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	
iter d ", or	Ę	3 Widowed 4 Divorced If Yes, Give Year 1958-60	es 2XX No specify:		Specify:	White
2 hours af "natural"	d by	15 Decedent's Education (Specify only highest grade completed) 16a Decedent's	s Usual Occupation (Give kind of st of working life, DO NOT use rel	work done (16	6b. Kind of Busines	s/Industry
72 ho n "na al Ex	ete	Elementary/Secondary (0-12) College (1-4 or 5+)	rance Underwrit		Insura	nce
036 ithin ne. r tha	Completed					
215-0036 be filed within 7 ntal Hygiene. sked other than ent, the Medica	ပိ	17. Father's Name (First, Middle, Last)		e (First, Middle, Mai	iden Sumame)	
21215-003 uld be filed withi Mental Hygiene. marked other tt	Be	W1111000 10 101111	Address (Street and Number or	Phipps	er City or Town Str	ate. Zip Code)
21 should and Men is man	6	19a. Informant's Name/Relationship (Type, Print) Mary Anne Kelly/wife 103 H	lickory Lane Ar	napolis,	Maryland	21403
MD and 2 sho alith and in 27 is			ion (Name of cemetery,		20c. Location - City	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Itealth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other trannante event, the Medical Examiner must be notified at once	ı	crematory or other	er place)	/4/2000	Namanalia	Marriand .
Pagenent Page	1		Mem. Gardens 6,			
Salt ermit. eparti nporti			ame and Address of Facility Jo			
	_	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the	Duke of Glouce	or respiratory arresi	Annapol	Approximate Interval
Physiciar /Medica		failure. List only one cause on each line.	e mode of dying, sadir do cardiae	, , <u>, , , , , , , , , , , , , , , , , </u>		Between Onset and Death
tamine		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):				
		or condition resulting in death) Due to (or as a consequence of):				
	9	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated				
Si d	Į	events resulting in death) Last Due to (or as a consequence of):				1 !
760, icate be executed sphysician and the burial - transit	5				_	
60, ate be ex hysician	Medical	UNPENDED AMENDED			23d. Date of deli	verv
876 ficate g phy	2	IF FEMALE: 23b. Was decedent pregnant in the 2. See July 23c. If yes, outcome of pregnancy 1. Live birth 2. Fet	al death 3 Ectopic preg	nancy	Month	Day Year
Sox 687 leath certific e attending 1 for use as th	/sician/	past 12 months? 4 Pregnant at time of death 5 Oth	ner (Specify)			
Box 687 e death certific the attending p	2	1 Yes 2 No 9 Unknown 9 Unknown			<u> </u>	
O. I	םוּ	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.			e to the cause of death? Probably 4 Unknown
P.O.	2	Chronic Alcoholism		-		
Records, P.O. The law requires that ficate has been signed to make 2 should be detailed.	Completed			24a. Was ai autops	y prior	e autopsy findings available to completion of cause of
e law	¹ c	<u> </u>		perform 1 ✓ Yes 2		h? Yes 2 No
tal Recician: The			26.Place of Death (Che	ck only one)		
of Vital ng Physician: After this certi		examiner? Hospital: Inpatient 2 FR/Outpatient	3 DOA Other Nur	sing Home 5 F	Residence 6	Other: Scene
of Viting Physic	≅ ⊢	27 Manner of Death 28a Date of Injury 28b, Time of I	njury 28c. Injury at Work?	28d. Describe he	ow injury occurred	
nding th.		1 V Natural 5 Pending (Month, Dey,Yeer)	1 Yes 2 No			
ivision or Attendafter death Director:	n 2	2 Accident Investigation 28e. Place of Injury - At home, farm, street	et, factory, office building, etc.			or Rural Route Number, City
Division (a) or Attendir rs after death. a) Director: A	Contification.	3 Suicide 6 Could not be determined (Specify)		or Town, St	ate)	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and constructions filled in the funeral director nace 2 should be detached for use as the burial. Harts			rred at the time, date and place, a	and due to the cause	e(s) and manner as	stated.
the l	i bie	Check only 2 Medical Examiner: On the basis of examination and/or investiga and manner stated. Check only 2 Medical Examiner: On the basis of examination and/or investiga and manner stated.	tion, in my opinion, death occurre	ed at the time, date a	and place, and due	to the cause(s)
- P - M - P - S	8 2	29b. Signature and title of certifier	29c. License number			(Month, Day, Year)
		Ly hu, no. 3	O.C.M.E.		May 31, 2009	3
		30. Name and address of person who completed cause of death (Item 23a)				
184		Ling Li, MD Assistant Medical Examiner 111 Penn Street	et, Baltimore, MD 21201			
× 111	Sta	te 31. Date filed (Month, Day, Year) 32. Registrar's Signature				
Reg			we			

19803

		1	For State Registrar	State of Ma		artment of H <i>rtificate of L</i>			ene_UUD g. No.	1 7000
			Decedent's Name (First, Middle, Last)		. 1 /			2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		ANTHONY	5 6	avetsk	-1		May	29, 2009	5:14 P M
	Examin		4a. Facility Name (If not institution, give	street and number)			Location of Death		4c. County of Dea	
			Anne Arundel Medic		(I In all black do.)	Annapo		8 Date of Birth	Anne Aru	
	Funeral Director		5. Social Security Number 6. Security Number 167–30–2558	7. Age M 2□ F	(In yrs. last birthday) 70 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, April 1	^{Year)} 6,1939 Per	thplace (State or Foreign ountry) Insylvania
	P		Usual Residence of Decedent		10c. City. Town or Lo	cation				10d. Inside City Limits
	arylar show		10a. State 10b. County MD Prince (Toc. City, Town of Lo		Bowie			1 ZXYes 2 ☐ No
	the M	ect	MD Prince (eorge s		10f. Zip Code		10	g. Citizen of What Co	ountry?
	with 3a or	Funeral Director	13410 Yorktown Di	rive		20'	715		USA	1
	ms 2	nera		12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whit	
9	or ite	y Fu	1 ☐ Never Married 2 ☑ Married	1 X Yes 2 □ N	D	1 □Yes 2 ☑ No			Specify:	White
21215-0036	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show yth, the Mederl Exonitive must be notified at	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edu	Year or Dates:1	16a Dece	dent's Usual Occup	pation		16b. Kind of Business	/Industry
7.	in 72 n "naf	Completed	(Specify only highest grad	e completed) College (1-4or 5-	(Give	kind of work done DO NOT use retired	during most of work	ring	D.L. Mead	le and
212	d with giene er tha	E O	Elementary/Secondary (0-12)	4	⁷ Inst	ırance Br			Associat	ces
	al Hy al Hy I othe	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nam		_	
yla	ould b Ment rarked latic e	은	Anthony Kavetski		1	4.11		.llie Amb	, City or Town, State,	Zin Code)
Maryland	12 sh sh and 7 is m traum		19a. Informant's Name/Relationship (T)				wn Drive,			2.15 0000)
ė,	1 and Healt iem 2		Carole C. Kavetsk	L/Spouse	20b. Place of Dispo cemetery, cre			Date	20c. Location - City o	r Town, State
lou	Pages nent of hant, if ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify,				tery 6/3/	2009	Bowie, Mar	ryland
Baltimore,	- + # · +		21. Signature of Funeral Service Licent			2. Name and Addre			uneral Hor	me
ä	Depar Impor any ir		1/ewillal						MD 20715	
			23a, Part 1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused ne cause on each lin	the death. Do not en	ter the mode of dyi	ng, such as cardiac	or respiratory arm	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Car	0101ula	nary!	trines.	/		ZUhoung
1	/Medical Examiner		resulting in death)	Du (or as	a consequence of):	- wend	clopath	(24hours
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence of):	Nag-1	500	~/		1 1000
	cuted nd ansit	Examiner	that initiated events	C			J .			
o,	e exerian ar urial-tu	Exi	resulting in death) Last	Due to (or as	a consequence of):			/		
68760,	icate be executed physician and the burial-transit	edical		d						
_		/Me	IF FEMALE:	23c. If yes, outcome					23d. Date of c	lelivery
Вох	death certif e attending id for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq Yes \) 2 \(\subseteq No \)	4 Pregnant a		☐ Ectopic pregnan ☐ Other <i>(specify)</i> _	cy		Month	Day Year
P.0.	at the de by the	hysi	9 □ Unknown	9 ☐ Unknown						to the serves of death?
	requires that the been signed by th hould be detache	by P	Part II. Other significant conditions co	entributing to death be	ut not resulting in the I	underlying cause gl	ven in Part I.			to the cause of death? Probably 4 nknown
Records,	w require been si should b									/~
Sec	e 2 s	Completed						24a. Was a autop perfor	sy prior t	autopsy findings available o completion of cause of ?
alF							00 Di		2 √No 1 □ Y	es 2 No
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 10	Hospital:	ent 2 ☐ ER/Outpatie	ent 3 DOA Ot	har:		lence 6 Other (S	pecify)
o	g Phy er this eral d	I⊢I	27. Manner of Death	28a. Date of Inju	ry 28b. Time		ury at	28d. Describe h	ow injury occurred	
ion	Attending F r death. ector; After by the funer	atio	1 Actural 5 ☐ Pending investigation		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,]Yes 2□No			
Division	l or Attend after death Director; d in by the f	Certification:	3 Suicide 6 Could not be determined	Zoe. Place of III)	ury - At home, farm, s c. <i>(Specify)</i>	treet, factory, office		28f. Location (S City or Tow	Street and Number or m, State)	Rural Route Number,
Ω	To the Hospital or within 24 hours after To the Funeral Director completely filled in b		29a. Certifier ertifying Ph	vsician: To the best	of my knowledge, dea	ath occurred at the	time, date and plac	e, and due to the	cause(s) and manne	as stated.
	e Hos 24 hc e Fun letely	Medical	(Check only 2 Medical Exam	ninet: On the basis of and manner st	f examination and/or	investigation, in my	opinion, death occ	urred at the time,	date and place, and o	lue to the cause(s)
	To the vithin To the comp	Me	29b. Signature and tille of certifier			29c. Licer	nse number	. 1	29d. Date signed (Mo	onth, Day, Year)
	11.	1	> LEU L			UM	3544	4	5/29/2	009
	50	1	30. Name and address of person who	completed cause of o	leath (Item 23a) (Type	Print)	Mode	J CD	to	
	Mo		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	, (out ()		7 -0	- Col	
	St Regist	ate rar	JUN 02 20	09 /2km	ar's Signature	ake				
	4MH 17 Boy 1/	0004		porter	- 1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 00:05 M June KELLER FLORENCE JOAN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** SA USBUK NICO MICO MANDE If Under 1 Year | If Under 24 Hr 8. Date of Birth (Month, Day, Year Oct • 5, 19 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, Social Security Number **Funeral** Days Months 1 □ M 2 🛛 F 192-26-4834 73 1935 Pennsylvania Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It a Medical Exeminer must be notified at 10d, Inside City Limits 10c. City, Town or Location 10b. County 10a State Marion Station 1 ☐ Yes 2 X No Director Maryland Somerset 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21838 38755 West Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status Black, White, etc. 1 □Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Banking Executive Bookkeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lydia Pahl Arthur Smith ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 28755 West Court - Marion Station, MD 21838 William B. Keller (Husband) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 🔽 Cremation 3 ☐ Removal from State 6/4/09 Salisbury, MD Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bradshaw & Sons Funeral Home 21. Signature Pheral Service Liouvice Robert H. Bradshaw, 306 W. Main St.-Crisfield, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Jause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): attending physician for use as the burial P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 5 Other (specify) cate has been signed by the a page 2 should be detached? 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 100 certificate has The 1 ☐Yes 2 ☐ No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2☑No 1 Impatient 2 I ER/Outpatient 3 I DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manger of Death Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after death. uneral Director; A 2 Accident filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salisbury MD EP 100 Carroll 31. Date filed (Month, State JUN 05 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Day 2009 Year **Physician** June 12, VINCENT RONALD KING 2:29 p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 1626 Bedford Street Cumberland Allegany If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) Oct 13, 1930 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Months 217-28-9313 MD Director 78 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Modeal Eventher it ust be nottled at MD Allegany Cumberland Director 1 □ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1626 Bedford Street 21502 USA Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ **X**o 14. Bace - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 □ Xo Specify \$ 3 ☐ Widowed 4 ☐ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other than 'any Injury or other traumatic event, the Meany Injury or other traumatic event, the Means in the College (1-4or 5+) teacher Board of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John King Pearl King ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley King wife 1626 Bedford Street MD 21502 Cumberland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Fernation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 6/16/2009 MD Cresaptown 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Fur eral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that course shock, or heart failure. List only one cause on each Approximate Interval Between Onset and Death ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) signed by the a 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ cate has been si page 2 should t 1 ☐ Yes 2 ☐ No S ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes 2 ☐ No 1 □Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

D35135

ORIGINAL

Seton Drive, Cumberland, MD 21502

June 15, 2009

State

Thomas E. Chappell
31. Date filed (Month, Day, Year) M D 912 Sc 32. Registrar's Signature JUN 1 9 2009 Registrar

30. Name and address of person who comp and cause of earth litem 23a) (Type, Print)

DK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Leverenz 2009 10:20 A M *sorma* 6 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 41 Moonshell Dr. Ocean Pines Worcester If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4/24/1928 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days 1 □ M 2**X**□ F 81 NY 122-16-5947 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No Ocean Pines Worcester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 41 Moonshell Dr. 21811 USA 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify: Specify: 3 XWidowed 4 ☐ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Urgel Proulx Albertine Jolicoeur 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Linda Herdering / daughter 2008 Bumblebee Rd., Accident, MD 21520 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 6/4/2009 Cape Henlopen Crem. Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) erosis Due to (or as a consequence of): Transfusions Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence or 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b Time of 28d. Describe how injury occurred

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Examine Physician/Medical ≥ Completed Be Certification: To

Medical

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f shor

permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event, the Medical Examiner manance.

Physician /Medical

Baltimore, Maryland 21215-0036

death with

Director

Funeral

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Completed

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MD

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

the Ste 104, Berlin, MD 21811 Franklin 31. Date filed (Month, Day,

State Registrar

6A 1

Year JUN U 5

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 11 11 11

		-	For State Registrar	of Maryland / Depa	rtificate of D	eath	Reg	1. No.2 () () 9	19807
	Physicia	an	1. Decedent's Name (First, Middle, Last) MATTEUS LUNTER				2. Date of Death Month JUNE	3 2009 Year	3. Time of Death 2:25 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and 11509 REED CIRCLE	number)	4b. City, Town, or L	ocation of Death		4c. County of Death	NE
	Funeral		Social Security Number 6. Sex	7. Age (In yrs, last birthday)		If Under 24 Hrs.	B. Date of Birth (Month, Day,	9. Birthp	place (State or Foreign htry)
	Director		215-28-2032 1 M 2 F	86 Yrs.		M	ARCH 18,	,1923 EST	ONIA
	yland how		10a. State 10b. County	10c. City, Town or Lo	cation			1	0d. Inside City Limits 1 □Yes 2 No
	Ba-fs	Director	MD CAROLINE	RIDGELY	10f. Zip Code		100	g. Citizen of What Cour	1/42
	3a or 2		10e. Street and Number 11509 REED CIRCLE		216	60		USA	
	ems 2	Funeral	11. Marital Status 12. Was D	ecedent Ever in U.S. 13.1 Forces?	Was Decedent of His If Yes, specify Cuban	panic Origin? (Spec , Mexican, Puerto F	cify Yes or No- lican, etc.)	14. Race - Ameri Black, White,	
36	filed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or items 23a or 28a-f show with the Marian Examinational be profilled at	by Fu	_ If Yes,	s 2 No Give r Dates:	1 □Yes 2 X No	Specify:		Specify: WI	HITE
9	2 hour	ted	15. Decedent's Education (Specify only highest grade complete	16a. Dece	dent's Usual Occupat	tion urina most of workin		6b. Kind of Business/In	dustry
21215-0036	vithin 7	Completed	Elementary/Secondary (0-12) College	e (1-4or 5+)	DO NOT use retired) N AND STEE			CONSTRUCT	TION
2	filed w Hygie other t ent, th	Be Co	17. Father's Name (First, Middle, Last)	TROP		18. Mother's Name	(First, Middle, Ma		
/lan	Mental Mental arked artic ev	To B	JOHN LUNTER			AMELIA			
Mar	h and 7 Is ma		19a. Informant's Name/Relationship (Type. Print)					City or Town, State, Zi	
ē,	f Healt tem 27		GLORIA LUNTER / WIFE 20a. Method of Disposition	20h Place of Dispo		Da		0c. Location - City or T	
<u>E</u>	Pages nent of int: If i		1 ☐ Burial 2 M Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)	CHESAPEAKI CENTER	E CREMATIO	N JUNE 6	, 2009	STEVENSVI	LLE, MD
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a five first Extending the notified all once.		21. Signature of Funeral Service Scensee		2. Name and Address ELLOWS, HEL	FENBEIN 8	NEWNAM CENTREV	FUNERAL HO	OME, P.A.
			23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of	at caused the death. Do not en	ter the mode of dying	, such as cardiac o	r respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition a.	ranic obst	RUCTIVE	Pulme	WIRY	NICEBE	
	/Medical Examiner		A Due	to (or as a consequence of):					
	p ±	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	to (or as a consequence of):	0 41 0051	101			
_	xecute and II-trans	Examiner	that initiated events C r	to (or as a consequence of):	3. WILDTI	VIO			
68760,	tificate be executed ig physician and as the burial-transit	edical E							
_	ertificating physe as the	Medi	IF FEMALE:						
Box	eath certif attending for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?		☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of deli Month	very Day Year
o.	the de by the ached	hysic		nknown					
s, P.	The law requires that the death certinate has been signed by the attending age 2 should be detached for use a	by P	Part II. Other significant conditions contributing	to death but not resulting in the u	underlying cause give	n in Part I.	23e. Did tob	s 2 No 3	the cause of death?
of Vital Records,	w requir been si should I						24a. Was ar		topsy findings available
Rec	he law e has l ige 2 s	Completed					autopsy	y prior to o ned? death?	completion of cause of
ital	lan: T	Be Co	25. Was case referred to medical			26. Place of Death	_		2010
) t	Physician: r this certific ral director,	ြို	A	Inpatient 2 ER/Outpatie		4 LI Nuising Ho		ence 6 Other (Spec	cify)
ono	Attending Frdeath. sctor: After by the funer.	tion:		Month, Day, Year)	Work		Edd. Describe no	W Injury Social Cu	
Division	or Atter after deaf Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 28e, P	lace of Injury - At home, farm, st uilding, etc. (Specify)	treet, factory, office		28f. Location (Str City or Town	reet and Number or Ru n, State)	ıral Route Number,
u	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		(Check only 2 Medical Axaminer: On t	o the best of my knowledge, dea he basis of examination and/or i	ath occurred at the tin investigation, in my o	ne, date and place, pinion, death occuri	and due to the cred at the time, da	ause(s) and manner as ate and place, and due	s stated. to the cause(s)
	o the Prithin 24	Medical	29b. Signature and title	manner stated.	29c. License			9d. Date signed (Mont	
	5 wit		1 / 100		075	780		06/05/	2009
	IUAS		30. Name and address of person who completed	cause of death (item 23a) (Type	e, Print)	~! A:=	0000	2000	200000
		ate	31. Date filed (Month, Day, Year)	7575 OTCUS 12. Regjetrar's Signature	E 1918/100	JY 618	1 (CD)(CN)	15 LOLDERAN ZI	and 2106/

State Registrar

JUN - 5 2009 Kenne

parker

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8 Ter FH G892 6/26/09 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Julia E. Lyles 02 06 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MOLTGOMER PARK MARTHUGIN POVENDIT HOP MIL MYCOMA Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 4930 Months Days Hours Min. Virginia 577-40-8693 1 □ M 2 😿 F 79 Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lujury or other traumatic event, I'm Mudoul Evantinational be notified at once. 10c. City, Town or Location 10a. State 10b. County Hyattsville 1 XIYes 2 ☐ No P.G. Md. **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 20782-2235 10e. Street and Number 1009 Chillum Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 **½**No If Yes, Give Year or Dat*e*s: 1 Never Married 2 Married Specify: Black Saltimore, Maryland 21215-0036 1 □Yes 2No Specify ģ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Housewife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bowles Bladley Minerva Robert ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1009 Chillum Road Hyattsville, Md. 20782 Everett M. Lyles/ Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, cramatory or other place)
CheltenhamVeterans June 11 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cheltenham, Md. 2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Robinson Funeral Home13136th St.NW Wash.
D.C. 20001 21. Signature of Funeral Service Licenses lolm 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) XSANGUIN **Physician** /Medical Due to (or as a consequence of): Examiner SAMI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to ar as a consequence of): Examine • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and neral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (spacify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 3 Probably 4 🔁 Unknown 2V No 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? Yes 2 10 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 es 2 No ical Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Injury 1 Natural 5 ☐ Pending investigation RUNTURE AU GRAN 630 PM 1 ☐ Yes 2 ☐ ₩6 SCONTHINEOUS 06-02-2009 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State)
1009 Chillum RD Moon PARC 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At hom building, etc. (Specify) At home, farm, street, factory, office determined 4 ☐ Homicide Home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) completely To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier address of person who completed cause of death (Item 23a) (Type, Print) Adventist Hosp. 7600 Carroll Ave-Takong Park Md. 30. Name an

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month May 2009 11:57 P M Carolyn Mary Lee 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Hyattsville Prince George's 1612 Erskine Street Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth June 24, 5. Social Security Number 7. Age (In yrs. last birthday) ^{Year}1924 Days Min Months 1 □ M 2 🗓 F 84 579-20-8789 Washington, DC Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 X Yes 2 ☐ No Prince George's Hyattsville Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1612 Erskine Street 20783 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 MYes 2 ☐ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Black. 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Army Nurse Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Snowden Mary George H. Lee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cheltenham, Maryland 10507 Westwood Dr. Gregory Lee/ Brother Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ☐ Removal from State June 16, 2009 Arlington, VA 4 ☐ Donation 5 ☐ 9ther (Specify) Arlington National 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of meral Service Licente 20019 4001 Benning Rd. N.E. Washington, DC Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 10 years Pulmonary Hypertension disease or condition resulting in death) Due to (or as a consequence of) 20 years Emphysema Sequentially list conditions, any localing to minute to cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 X No 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) 1∐ Yes 2∭XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work?

Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trar Division of Vital Records, P.O. Box 68760, After this 24 hours after death.

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Physician

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, The Medical Evanines mass to 28a-f show once.

1 XNatural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide (Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

essuns MD

MD 31449

June 4, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Laura L. Sessums, JD, MD, FACP 6900 Georgia Avenue 20307-5001 Washington, DC

State Registrar

within 2 To the I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland? Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 12:50 PM MODLIN **JAMES** WILLIAM JUNE 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CHARLES LA PLATA CIVISTA MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) WASHINGTON, DC 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Hours Days 1 M 2 □ F 66 Yrs. 213-42-9511 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State Department of Health and Mental Hygiene. mportant; if item 23a or 28a-f show mportant; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantion in the natified at 1 ☐Yes 2 X No Director WALDORF CHARLES MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20601 5412 LUCY DRIVE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1∐Yes 2**√∑X**o Specify: Specify: WHITE 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR OF CARGO DEPT. OF DEFENSE 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LOUISE CURTIS NATHAN HENRY MODLIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5412 LUCY DRIVE WALDORF, MD 20601 JUDY MODLIN/SPOUSE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages ' JUNE 18,2009 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ALEXANDRIA, VA METRO.CREMATORY 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility RAYMOND FUNL.SERVICE, P.A. 5635 WASHINGTON AVE., LA PLATA, MD 20646 21. Signature of Funeral Service Ligense M00641 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, sur shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death as cardia or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequi Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine Hospital or Attending Physician; The law requires that the death certificate be execute attending physician and for use as the burial-tran Due to (or as a consequent Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) □Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ੬ 1 res 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 NO 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1/ Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760,

MODLIN

10

DIL

enna Medical Center 7-C Post CAFICE Rd. Waldorf, No 2600

Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUN 1 9 2009

32. Registrar's Signature

Umais

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

	Examin	er	4a. Facility Name (If not institution, give stree	t and number)	4b. City, Town, or Location of Deatl	1	4c. County of Death
N.			Washington Count		Hagerstown		Washington
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bi	Months Days Hours Min	(Month, Day, Ye	9. Birthplace (State or Foreign Country)
	Director		199-07-6303	90	Yrs. Months Bayo House Minn	October 7	,1918Pennsylvania
	pud *		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	on or Location		10d. Inside City Limits
	sho	'n		,			1 ☐Yes 2 ☑ No
	Ba-f	Director	Maryland Washingt	оп нас	gerstown	Las	
	ith ti	ä	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?
	ath v	Funeral	11400 Stonecrof		21742		U.S.A.
	er de	un n	Tr. Marital States	Vas Decedent Ever in U.S. rmed Forces?	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	s afte			∐Yes 2 X No Yes, Give	1 ☐ Yes 2 XNo Specify:		Specify: White
21215-0036	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Evandrat must be notified at	Completed by	,,	ear or Dates:	December Herry Consumption	10h	Kind of Duninggalladustry
15	"nat	lete	15. Decedent's Education (Specify only highest grade controls)		 Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) 	king	. Kind of Business/Industry
12	vithir		Elementary/Secondary (0-12)	College (1-4or 5+)	Homemaker		Own Home
	S should be filed within and Mental Hygiene. is marked other than " aumatic event, the Ma		17. Father's Name (First, Middle, Last)	<u> </u>		ne (First, Middle, Maid	
an C	ntal I	Be		D. J. L. L.		,	
3	should and Mer s marke umatic	욘	James Rankin	T			Stumbaugh
Jai	h and		19a. Informant's Name/Relationship (Type. I	· _	o. Mailing Address (Street and Number or Ru		
6	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, if a Modical Examiral mast te notified at	L.j	Robert C. Marquart		O Bethlehem Court, H		
0	Pages 1 ar nent of Hea ant: If item 3 ury or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remo	vai irom State	of Disposition (Name of ery, crematory or other place)		. Location - City or Town, State
Ë	tmen tant:		4 Donation 5 DOther (Specify)	Cedar	Lawn Memorial Pk. 06		gerstown, Maryland
Baltimore, Maryland	permit. Page Department o Important: If any Injury or once.		21. Signature of Funeral Service Licensee	/	22. Name and Address of Facility Andrew K. Coffman	Funeral H	ome. Inc.
_	<u>~</u> □ = # 9		R. hoel Bra	dy	40 East Antietam	Street, Ha	gerstown, Md. 21/40
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one can	hat caused the death. Do	not enter the mode of dying, such as cardia	or respiratory arrest,	Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition	Preumom	a		Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence			gra there
	Examiner		b =	Renal Far	lure		Two weeks
	7 +	ner	Sequentially list conditions, b.	Due to (or as a consequence	of):		Two weeks
	cuter nd ransi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Clostndium	Difficule Colitis		Ino welks
Ô	e exe an al rial-t		resulting in death) Last	Due to (or as a consequence	of):		
68760,	icate be executed physician and the burial-transit	ical	d				
9	rtifice ng ph as th	Jed	IF FEMALE.				
Вох	eath cert attendin	N/UE	23b. was decedent pregnant	f yes, outcome of pregnancy	h 3 Ectopic pregnancy		23d. Date of delivery
Π.	dea ne att	icie	1 Yes 2 No	Pregnant at time of death	5 Other (specify)		Month Day Year
P.0	s that the death certificate be executed ined by the attending physician and e detached for use as the burial-transit	Physician/Medical	9 Unknown	9 LI OTIKNOWN			
'n.	gned e de	>	Part II. Other significant conditions contribu	iting to death but not resulting	n the underlying cause given in Part I.		co use contribute to the cause of death?
ğ	The law requires ate has been sign age 2 should be	q pa		C OBSTYUL	tre ling or seare	1 ☐ Yes	2 No 3 Probably 4 Unknown
ပ္ထ	law re as be 2 sho	olet	Conge	Twe lear	r farline.	24a. Was an	24b. Were autopsy findings available
æ	The la	Completed				performed	prior to completion of cause of death?
tal		Ü	25. Was case referred to medical		26. Place of Do	1 ☐ Yes 2 ☑ ath (Check only one)	No 1 ☐ Yes 2 ☐ No
Division of Vital Records,	Physician: r this certific ral director, I	00	examiner? 1 ☐ Yes 2 ☐ No	tal: 1 Inpatient 2 ☐ ER/O	Othor:		e 6 ☐ Other (Specify)
of	y Phy er this eral c	7: T 0	27. Manner of Death 2	8a. Date of Injury 28b.	Time of 28c. Injury at	28d. Describe how in	
o	th. Funda	ţi	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury Work? M 1 □Yes 2 □ No		
İSİ	Attending in death. ector: After by the fune	fice	3 Suicide 6 Could not be	Be. Place of Injury - At home, for	arm, street, factory, office	28f. Location (Stree	t and Number or Rural Route Number,
Ö	after after d in t	Certification:	4 ☐ Homicide determined	building, etc. (Specify)		City or Town, S	tate)
	spita nours nera v fille		29a. Certifier Certifying Physicia	n: To the best of my knowledg	e, death occurred at the time, date and plac	Ie, and due to the caus	se(s) and manner as stated.
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	(Check only 2 Medical Examiner: one)	On the basis of examination a and manner stated.	nd/or investigation, in my opinion, death occ	urred at the time, date	and place, and due to the cause(s)
	Within To the comp	M	29b. Signature and title of certifier		29c. License number		Date signed (Month, Day, Year)
			23-1		D44996	te	ine 8, 2009
			30. Name and address of person who compl	eted cause of death (Item 23a)	(Type, Print)	/	
9	4-3		Zafar Malik 1	10 20311	(Type, Print) appoins Rd Boons	SOW MI	2/7/3
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature			
	Registr		JUN 0 9 200		ha del		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009 8:32 A M Nancy Viola Myers June 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington 7 East Washington St. Apt. 3001 Hagerstown Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 1□M 2 F Days 220-28-2810 Jan.11, 1933 Maryland 76 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 X Yes 2 No Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7 East Washington St. Apt. 3001 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ŽŽNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Wiley Letha Olive Edward State Malott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 16640 Broadfording Rd. Hagerstown, Maryland 21740 Kenneth L. Myers, Jr. - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial _2 □ Cremation 3 □Removal from State 5 Other (Sp Greenlawn Mem. Park June 9,2009 Williamsport, Maryland 4 ☐Dopation 21. Sign fure of Juneral Osborne Aftenerally Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LUNG CARCINOMA Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an performe 2 1 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral Directo

Completed by

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Records.

Division or Vital

Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Completed by Be Certification: To

27.

Medical

IF FEMALE: 9 Unknown DIABETES COPD 25. Was case referred to medical

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

1 ☐ Yes 2 ☑ N	0	Hospital:	1 🗌 Inpatient	2 🗆	ER/Outpatient	3 🗆 🛭	AOC	Ot
Manner of Death 1 Natural 2 Accident	5 □ Pending investigation		Date of Injury (Month, Day Yo	ear)	28b. Time of Injury	М	28c.	Inju Wo
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	286.	Place of injury building, etc. (- At h	ome, farm, stree	t, facto	ory, of	fice

Other: 4 ☐ Nursing Home 5 MResidence 6 ☐ Other (Specify) 3□ DOA toatient Time of M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

26. Place of Death Check onl one

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

6-5-09

28d. Describe how injury occurred

HAGERSTOWN, MD 21740

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number DO057285 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G. JOHNSON KOTLPILLAI Z4 N. WALNUT ST.

31. Date filed (Month, Day, Year) State

29a. Certifier

32. Registrar's Signature

2 Medical Examiner

Bener S. Jak

DHMH 17 Rev 1/2001

Registrar

12H-2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 11 Day 2009 e ai 6:20 a_M . HONE **Physician** NANCY JOHNSON MOORE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Kent Heron Point-Talbot Wing Chestertown 8. Date of Birth (Month, Day, Year) Aug 1 1930 9. Birthplace (State or Foreign f Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. New York 1 □ M 2 🗓 F 78 041-26-8794 Director Usual Residence of Decedent 10d. Inside City Limits 10h Count 10c. City, Town or Location 10a State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "Andral Experime must be notified at 1⊠Yes 2□No MID Kent Chestertown Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. 21620 127 Heron Point Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 72 hours after 1 □Yes 2K No 1 □ Never Married 2 □ Married White Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 No Specify: Specify: <u>გ</u> 3 N Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home d 2 should be filed well and Mental Hygier 7 is marked other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Boyd George O. Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health as Important: If item 27 is any Injury or other trau 2206 Shuresville Rd. Darlington, MD. 21034 David Moore (son) 3altimore. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 6/12/09 Smyrna, DE. Kent Cremation Service 4 Donation 5 Dother (Specify) ²² Name and Address of Facility Galena Funeral Home of Stephen L. Sc 118 West Cross St. Galena, MD. 21635 21. Signature of Fun ral Services Schaech M00510 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, gr heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? (es 2 No 1 ☐ Yes No. certificate 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be funeral director, Other: 2 446 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1∐ Yes 1 Inpatient 2 ER/Outpatient 3 IDOA Certification: To this 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? After 1 Injury 5 Pending investigation n 24 hours after death.

Re Funeral Director: Af pletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 ho

To the Fune and manner st 29b. Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 8 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Ye ar Month 620 M Physician IAN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Mandrin Chesapeake Hospice House Harwood If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country)
New York 8. Date of Birth (Month, Day, Yea 12/7/1920 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2□F Yrs. 88 060-14-6918 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It a Modical Experiment result be notified at 1 X Yes 2 □ No Director Pinellas Pinellas Park Florida 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3641 93rd. Ave. 33782 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Secretary/Homemaker Federal Gov./Home 12 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leonard Terrono Lena Maier ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Frank R. LaMacchia/Husband 3641 93rd. Ave. Pinellas Park, FL. 33782 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 6/4/2009 Edgewater, Maryland Kalas Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature Funeral Service Licenses ales 2973 Solomons Island Rd. Edgewater MD. 23a. Part i. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory at shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): attending physician for use as the burial Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) signed by the a d be detached for P.O. 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 3 Probably 4 Unknown 1 🗌 Yes 2 No page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed Physician: The 1 ☐ Yes 2 ☐ No 2 1 Tyes director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence PICC 1 Yes 2 🗆 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t HUUST To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1730 1 Natural 5 ☐ Pending investigation 57000 UP hitread 05.26:09 1 ☐ Yes 2 ☑ No 2 Accident 3 ☐ Suicide completely filled in by the 6 Could not be (Street and Number or Rural Route Number, 74 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street ar City or Town, State Y | PPACH 4 ☐ Homicide where She Was VISITING TREE LN, True Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29g. Date signed (Month, Day, Year) 29b. Signature and title of certifier on who completed e of death (Item 23a) (Type lame and address of peri My И

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

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		1 - State Registrar	of Maryland	-	artment of H r <i>tificate of</i>			iene	19815
Dhust		Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
Physic /Med		GIUSEPPE MARANGI					JUNE 1	, 2009	02:57 P. ^M
Exam	iner	4a. Facility Name (If not institution, give street and ANNE ARUNDEL MEDICAL C	,			r Location of Death NAPOLIS		4c. County of Death	
Funera		Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth		place (State or Foreign
Directo	r	219-13-8905 1X M 2 1	65	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, JUNE 22,	1943	ITALY
/land		Usual Residence of Decedent 10a. State 10b. County	10c. City	Town or Lo	cation				10d. Inside City Limits
e Mar	Director	MARYLAND ANNE ARUNDE	L		AN	NAPOLIS			1 ☐ Yes 2 X No
with th		10e. Street and Number			10f. Zip Code	01/01	10	Og. Citizen of What Cou	untry?
iore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it a Marical Exp. Juriar must be a public at	Funeral	1 2nd STREET 11. Marital Status 12. Was D	ecedent Ever in U.S	. 13. \	Was Decedent of H	21401 dispanic Origin? (Span, Mexican, Puerto	pecify Yes or No-	14. Race - Amer	
36 after or ite		1 Never Married 2 Married 1 Yes	Forces? s 2 X No Give		f Yes, specify Cub 1 □Yes 2 🕱 No		Rican, etc.)	Black, White	
Maryland 21215-0036 ad 2 should be filed within 72 hours aft lth and Mental Hygiene. It is marked other than "natural", or traumatic event, it a Modical Exp. in traumatic event, it a Modical Exp. in	ed by		r Dates:		dent's Usual Occup		Ĭ.	16b. Kind of Business/li	ITE ndustry
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and d be fill ental H eed out	Be	17. Father's Name (First, Middle, Last) ANTONIO MARANGI					e (First, Middle, N	faiden Surname)	
laryland 2121 2 should be filed within and Mental Hygiene. Is marked other than aumatic event, tre M.	ြင	19a. Informant's Name/Relationship (Type. Print)		19b. Mailir	ng Address (Street	and Number or Rui		City or Town, State, Z.	ip Code)
and 2 and 2 ealth a n 27 is		ANTONELLO MARANGI/SON				, CROWNSV	ILLE, MA	RYLAND 210	32
Baltimore, permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other		20a. Method of Disposition 1 □ Burial 2 🛣 Cremation 3 □ Removal from	om State CHE	APEAK	sition (Name of natory or other old		3	20c. Location - City or T	
Itim sit. Pa sit. Pa artmer ortant:		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Liceosee	CEN	rer –		į	2009 S	TEVENSVILL	E, MARYLAND
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Vital I sician: Th certificate irector, pag	Be Co	25. Was case referred to medical	uscului	C	K14 864 €		1 ☐ Yes 2	2 □ Yes 1 □ Yes	2 □ No
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IVISION After ter deat irector:	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Pla	ace of Injury - At hon ilding, etc. (Specify)	ne, farm, stre		Yes 2 □No	28f. Location (Str City or Town	reet and Number or Ru , State)	ral Route Number,
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical Ce	29a. Certifier 1 Certifying Physician: To (Check only one) 1 Medical Examiner: On the control of	e basis of examinati	rledge, death on and/or in	n occurred at the ti	me, date and place opinion, death occur	, and due to the ca	ause(s) and manner as ate and place, and due	stated. to the cause(s)
To the within I To the Somple	Med	29b. Signature and title of certifier	anner stated.		29c. Licens	se number	29	d. Date signed (Month	, Day, Year)
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10 CH		30. Name and address of person who completed c	ause of death (Item	23a) (Type,	Print) AAN	1c An	noneli	6-1-2 5/UD a	214/0
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 2009 0801 June Geraline Matthews /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Anne Arundel Medical Center Annapolis Birthplace (State or Foreign Country) 8. Date of Birth Min. 90pt 27 If Under 1 Year | If Under 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) ^{Year)} 1927 **Funeral** Hours Months Days \$ept Maryland 1 M 2 F 214-44-3955 81 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Exercities must be notified at Ne Yes 2 □ No Directo Annapolis Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21401 130 Hearne Rd. Apt 914 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: Black <u>Ş</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel Co. Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Board of Education 0 Cafeteria 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gertrude Scott Octif Turner ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 130 Hearne Rd. Apt 914 Annapolis, Md. Calvin C. Matthews(Husband) Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Varie of Cemetery, drematory of cities place) permit. Pages 1 Department of H Important: If ite any injury or ol once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Church 6-5-09 Shady Side, Md. U.M. 4 ☐ Donation 5 ☐ Other (Specify) Windlame Redected of Secilisions Mortuary, 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 821 West St. Annapolis, Md. Approximate Interval Between Onset and Death **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) signed by the a ☐Yes 2 No 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been s irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) this c I dire 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After Injury 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death

Director: A 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled ir Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical cal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of c ctifier 06-03-09

State Registrar

DHMH 17 Rev 1/2001

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#231 Annapolis MD 81407

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} **2009** 08:51 P M 29, BARBARA JANE MORRIS 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours Min 1 □ M 2 🗶 F OCTOBER 30, 1932 WASHINGTON, DC 577-42-9116 76 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location 1 ☐ Yes 2 No GAMBRILLS MARYLAND ANNE ARUNDEL 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED STATES 21054 2606 CHAPEL LAKE DRIVE, #112 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐Yes 2 X No If Yes, Give Year or Dates 1∐Yes 2**X**No Specify: WHITE Specify: 3 X Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DEPARTMENT OF COMMERCE ADMINISTRATIVE ASSISTANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) FRANCES ROBERTS THOMAS GAYLE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 48 RIDGE AVENUE, EDGEWATER, MARYLAND 21037 LINDA SUSAN LAMOM/NIECE 20b. Place of Disposition (Name of CHESAPEAKE) CREMATION CENTER 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State MAY 31,2009 STEVENSVILLE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM CREMATION AND FUNERAL CARE 1701. 814 BESTGATE ROAD, ANNAPOLIS, MARYLAND 21401. 21. Signature of Funeral Service Live 7M00672 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): utcome of pregnancy 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) gnant at time of death nown 23e. Did tobacco use contribute to the cause of death? death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 □No 26. Place of Death (Check only one) Hospital

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

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Hospital or Attending Physician: The law requires that the death certificate be execute burial-tran the attending pl been signed by the should be detached certificate has be rector, page 2 si director, this funeral thin 24 hours after death.

the Funeral Director: After the function by the function of the fu

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner Completed by Be Certification: To

Medical

State Registrar

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2□Vo 9 □Unknown	23c. If yes, ou 1 🔲 Live 4 🔲 Pres 9 🗀 Unk
Part II. Other significant condition	

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of De Natural 5 Pending investigation 2 Accident

Date of Injury (Month, Day, Year) 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 □Yes 2 □ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier werns, MD 29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 03ª 2009 **Physician** 02:25 A. M Jüne Ollie C. Motley /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's Lanham Magnolia Center Nursing Home If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours North Carolina 1 □ M 2 🔀 F 92 0771271916 228-24-9616 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director Cheverly P.G. Md. 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. 20785 6509 Maureen Court Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: Black altimore, Maryland 21215-0036 1 ☐Yes 2XNo Specify 2 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Is marked other than College (1-4or 5+) Elementary/Secondary (0-12) Private Homes Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Martha Montgomery Tony Cannon ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6509 Maureen Ct., Cheverly, Maryland 20785 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any Injury or other trau Daisy M. Madison/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 06/09/09 Brentwood, Maryland Ft. Lincoln Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Assons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ARCINOMA PANCREAS WITH META 1 month **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a some squence of). Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Ye ar 5 Other (specify) cate has been signed by the a page 2 should be detached to □Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Osteoponosis 24a. Was an autopsy performe certificate 1 ☐Yes 2 ☐ No 1 □Yes 2 ☑No Division of Vital funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To After this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

completely

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Medical

29a. Certifier

(Check only

29b. Signature and title of certifie

4 203 Queenstury Rd Hyattsville NW 20781 DEVORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Physician /Medical **Examiner** Examine

permit, Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If tem 27 is marked other the any injury or other traumatic event, If an once.

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Baltimore, Maryland 21215-0036

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31. Date filed (Month, Day, Year,

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requires that the death certificate be execu and burial-trar the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifica funeral completely within 24

Division of Vital Records, P.O. Box 68760,

resulting in death) Last	Due to (or as a conseq	quence of):						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23d. Date of delivery Month Day Year						
Part II. Other significant conditions of End Stage Ren	5	sulting in the underlying	ng cause given in Part f.		cco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 🔀 Unknown			
				24a. Was an autopsy performe 1 □ Yes 2X	24b. Were autopsy findings available prior to completion of cause of death? □ No □ □ □ Yes □ □ No			
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1₭ Inpatient 2□	1 FD (0 1 1 1 1 5 F		eath (Check only one)				
27. Manner of Death 1 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28d. Describe how	ence 6 Other (Specify) ow injury occurred				
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, fac fy)	etory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)			
29a. Certifier (Check only one) 1 ☑ Certifying Ph 2 ☐ Medical Exam	ysician: To the best of my knowing: On the basis of examination and manner stated.	owledge, death occur ation and/or investiga	rred at the time, date and pla ttion, in my opinion, death oc	ce, and due to the cau curred at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)			
29b. Signature and title of certifier			29c. License number	29d	9d. Date signed (Month, Day, Year)			
H111/	1	ND	D67589	06				
30. Name and address of person who	completed cause of death (Iter	m 23a) (Type, Print)						
Harol √. Lawson 15	00 Forest Gle	n Road Sil	ver Spring, N	maryland 20	910			

32. Registrar's Signature

			1 - For State Registrar	State of Mary		partment of Hertificate of		Reg.	711119	19820											
× 1	Physici /Medio	al	Decedent's Name (First, Middle, La Laura Elysebeth M Aa. Facility Name (If not institution, giv	ays		4h City Town o	r Location of Death	June 3	Day Year 2009 4c. County of Deatl	3. Time of Death 10:00 A M											
	Examir Funeral	ier	Charles County Nu 5. Social Security Number 6. S	rsing Home	n yrs. last birthday	LaPlat			Charle:												
*	Director	Ż	578-68-9431 Usual Residence of Decedent 10a. State 10b. County)4 Yrs. Oc. City, Town or L			Sept. 13,		ryland 10d. Inside City Limits											
ore, Maryland 21215-C ss 1 and 2 should be filed within 72 h of Heelth and Mental Hygiene.	r 28a-f ahor r 28a-f ahor r cotified at	Irector		Georges		dywine 10f. Zip Code		10g.	Citizen of What Co	1 ☐ Yes XX No											
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	be filed within 72 ho tal Hygiene. d other then "netui avent, the Modical	Completed	15. Decedent's E. (Specify only highest gra		(Giv life.	edent's Usual Occup re kind of work done DO NOT use retired	during most of wor		. Kind of Business/												
	be d la be	To Be Co	12th. 17. Father's Name (First, Middle, Last, H. Bruce Burrough		HO	ne Maker		ne (First, Middle, Maid		2											
	1 and 2 sh Heelth and am 27 is m thar traum	-	19a. Informant's Name/Relationship (Laura Verge/ Daug 20a. Method of Disposition 1 A Burial 2 Cremation 3 Companies of	nter Removal from State	11801 20b. Place of Disposemetery, or Huntt Fan	Crestwoo position (Name of ematory or other place nily Cemet 22. Name and Addre	ed Avenue ery June	7, 2009 W ntt Funera	andywine Location-City or aldorf, N 1 Home	MD. 20613 Town, State											
i i	Physician		23a. Part1. Enter the disease, or con shock, or heart failure. List only tmmediate Cause (Final disease or condition resulting in death)	and aquee on each line	e death. Do not e	nter the mode of dyir	ng, such as cardiad		orf, MD.,	Approximate interval Between Onset and Death											
W 160, Medical safe percented whisicien and whisicien and the burial-transit	ate be executed hysicien and the burial-transit	Completed by Physician/Medical Examiner	by Physician/Medical	by Physician/Medical	by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co	onsequence of):	ry arter	ial d	failure isease		Years.								
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2	w requires that the de been signed by the a should be detached t														s contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3						V
Vital Records,																		24a. Was an autopsy performed	r? prior to death?	utopsy findings available completion of cause of 2 No	
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ō	ding Phys h. After this funeral di	on: To	1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pending	1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpati 28b. Time lnjury	of 28c. Injur	ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred														
Division	i or Attandi after death. Diractor: A in by the fu	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	e Ogo Place of Ising		M 1 Yes 2 No			(Street and Number or Rural Route Number, wn, State)												
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	edical Co	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of m niner: On the basis of ex and manner stated	amination and/or	ath occurred at the tir investigation, in my o	me, date and place opinion, death occu	a, and due to the caus irred at the time, date	e(s) and manner as and place, and due	s stated. to the cause(s)											
)	To the within To the the to the to the the the the the the the the the the	Me		'Sindlein			o 61614	29d.	Date signed (Mont	h, Day, Year)											
100	DB5 Sta	ite	30. Name and address of person who some and address of person who some addr	completed cause of death	1 Su	e, Print) itc/0/ backer	Wald	ert, MD	20602	2											

09-04624 Scott Allan Martin Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

			- For State		(Certifica	te of I	Death					Reg. No					
	Physicia		2. Date of Death									Year	;	3. Time of Death				
1	' Examir	ner	Scott Allan Martin June 10, 2009 1658 hrs										1000 1118					
			4a. Facility Name (if not institution	umber)				Death			4c. County of Death Baltimore County							
			4730 Painters Mill Ro	ad				Owings					- 1			•		
	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday						If Under	Year Days	If Under Hours	24Hrs. Min.			Į.	Foreign	place (State or		
	Director		213-88-0917	1X M 2 F	43		Yrs.					Mar	18,	1966	Cou	ntry) MD		
		-	Usual Residence of Decedent		140-	Oit Tour	- Lacatio						_			10d. Inside City Lin	mits	
	w any	10a. State 10b. County 10c. City, Town or Location											1	1 Yes 2	No			
	Maryland 28a-f show d at once,	ō	PA York			Hanc	ver	405 75- 0					10a C	itizen of Wha	t Coun	Λ		
3	D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What								Coon							
)	h the l'3a or										Americ	an Indian, Black,						
K.,	th wit	Funeral	11. Marital Status1 Never Married 2 Notes		cedent Ever orces?	IN U.S.	If Ye	s Decedent es, specify (Cuban,	Mexican,	Puerto R	ican, etc.)		White,				
\	or dea	ᇍ		1 Yes	2 X	No	1	Yes 2	- No	specify:				Specify:	white			
	rs afte	2	15. Decedent's Education (Spe	l or Dates:		ed) 16a. [Decedent	's Usual O	cupatio	n (Give ki	ind of wo	rk done	16b	. Kind of Busi	iness/li	ndustry	\neg	
	2 hou "nat	ompleted	Elementary/Secondary (0-12)		(1-4 or 5+)		during mo	st of worki	ng life. I	DO NOT u	ise retire	d)	1					
	thin 7	힐	12			1	mach	ninist							ngineering			
	5-0036 iled within 7 Hygiene. I other than the Medica	녌	17. Father's Name (First, Middle	e, Last)					18	8.Mother's	Name (e (First, Middle, Maiden Surname)						
	21215 ould be file Mental H marked ic event, t	Be	Lee Martin							Kath	y Sh	ouse.	Fraz	zier				
	21 nould d Me is man	2	19a. Informant's Name/Relation			191	. Mailing	Address	(Street	and Numi	ber or Ru	ıral Route N	Number,	City or Town	, State	, Zip Code)		
	Z d d Z mm		Kimberly S. M.	<u>lartin, wi</u>	fe .	54 20b. Place o	0 Sc	Fra	nkl	in S	tree	t, Ha	nove	er, Pa	r. Pa. 17331 Location - City or Town, State			
	ore, MD 21215-0036 pes I and 2 should be filed within 72 of Health and Mental Hygiene. If item 27 is marked other than ther traumatic event, the Medical		20a. Method of Disposition 1 Burial 2 Crematic	on 3 Removal	from State	cremate	ory or oth	ner place)		,,								
	Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner	1	4 Donation 5 Other S	Specify:	_ []	Lake V						5/200	9 8	Sykesv:	<u>ill</u>	e, Md.		
	alti rmit spartn sport	ı	21. Signature of Funeral Service	ensee	M00	741	22. N	lame and A	ddress	of Facility	El	ine F	unei	cal Hor	me			
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t	ীysician /ledical		failure. List only one caus	e on each line.				ie mode or	dynig, a	50011 03 00	10000	reopilatory	u., 001,			Between Onset Death		
	∠xaminer	- 1	Immediate Cause (Final diseas or condition resulting in death)				Lon					_	_			-	-1	
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	587 ertific fing p	an/	23b. Was decedent pregnant in past 12 months?	D.	birth					Ectopic	pregna	ncy	- 1	Month		Day Year		
	Box 68: death certifi the attending ed for use as is	sici	1 Yes 2 No 9 U	Inknown []	gnant at time known	eordeaur	5 Ot	ther (Spec	fy) _				- 1				1	
	the de	Physician	Part II. Other significant cond			t not resultin	ng in the u	underlying	cause g	iven in Pa	art I.	23e. D	id tobac	cco use contr	ibute to	the cause of death	h?	
	ires that the signed by the detached	ρ			•							1	Yes	2 No 3	Pro	bably 4 🗸 Unkn	own	
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	the I thin 2 the I	Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day										the cause(s)						
4	Signature and title of certifier									9d. Date sigr	gned (Month, Day, Year)							
•	WIL		O.C.M.E. June 11, 2009															
	' 0		30. Name and address of person who completed cause of death (Item 23a)															
			Zabiullah Ali, M.D.	Assistant Med				nn Stree	t, Balt	timore,	MD 21	201						
		tate	III AI		Registrar's	Signature	1											
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Registrar
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** K. Georgeanna Mainhart 29 2009 11:15 A May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 602 Binsted Road Anne Arundel Glen Burnie If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 22, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Year Months Hours 1 □ M 2 🖫 F 80 Maryland Director 218-28-3270 1929 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Marylanc 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show r than "natural", or Items 23a or 28a-f shorter Medical Examiner must be notified at MD Anne Arundel Glen Burnie Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21060 602 Binsted Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No White Specify: Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Anne Arundel Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. em 27 is marked other thar other traumatic event, II and County Schools Substitute Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard W. Kerr, Sr. Georgia Stanfield ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven R. Mainhart / Son 314 Stevens Avenue Arnold, MD 21012 permit. Pages 1 and Department of Health Important: If item 27 any Injury or other to once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date June 03 1 ▼Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Sykesville, MD Lake View Memorial Park 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 12 al disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of): physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t performed certificate 1 ☐ Yes 24 No 1 ☐Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No ours after death.

neral Director: #
filled in by the for 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 I Homicide Hospital 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the Hospital
Within 24 hours a
To the Funeral
Completely filled

State 31. Date filed (Month, Day, Year)
Registrar JUN 02

29b. Signature and title of certifie



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and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month 13:35P **Physician** James West McFarland 2009 05 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Agnes Baltimore If Under 1 Year If Under 24 Hrs. NOSP Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Hours 89 Months Days 1 X M 2 □ F 1920 Pennsylvania Yrs. 184-14-2654 Jan. 01, Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Catonsville Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event. It we Wedical Examinations to be notified at 10a. State Baltimore MD 1 ☐ Yes 2 ☑ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21228 715 Maiden Choice Lane, PV 116 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No WWII If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2X Married White Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Art Graphic Artist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Berta Elizabeth Spear James Caldwell McFarland ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 715 Maiden Choice Lane, PV 116 Catonsville, MD 21228 Margaret H. McFarland / Wife permit. Pages 1 and Department of Health Important: If Item 27 any injury or other troone. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20a Method of Disposition June 01, Baltimore, MD 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, INC. 2009 4 □ Donation 5 □ Other (Specify) Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 21. Sign stire of Fundral Servi Licensee 23a. Part1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 48 15 intection **Physician** urnary , /Medical Due to (or as a consequence of): **Examiner** pseudo mon as Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed 114 attending physician and for use as the burial-tran Due to (or as a consequence of Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month 5 Other (specify) ☐Yes 2☐No 9 Tunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗆 No 1 ☐ Yes certificate 1 □Yes or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 \(\Bigcap \) Nursing Home 5 \(\Bigcap \) Residence 6 \(\Bigcap \) Other (Specify) Hospital: 1 Umpatient 2 ER/Outpatient 3 DOA 1 Tes 2 No Certification: To After this 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death Injury 1 ☑ Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD Vandana 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Dalagiri Vandana

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

park

32. Registrar's Signature

Treva

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #17 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Di 2009 June Ann Milligan Judy 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) SAUSBUM Wiamito KEGIONAL If Under 1 Year | If Under 24 Hz Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Hours Months Days 1 □ M 2 F Maryland 215-66-9534 53 09-26-1955 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No Westover Somerset 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 26868 Fairmount Road 21871 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★ No 11. Marital Status 1 □Yes 2 No 1 Never Married 2 Married Specify. If Yes, Give Year or Dates: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) U.S. Postal Service none Postmaster 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William K. Mills Eugene Townsend Mitchell Ruth Ann Howard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 26868 Fairmount Road, Westover, MD 21871 Bruce Milligan/Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Method of Disposition 1 Burial 2 Cremation 3 Removal from State Beechwood Cemetery 06/05/2009 Princess Anne, MD 4 ☐ Donation 5 ☐ Other (Specify) ionature of Funeral Service Licensee 22. Name and Address of Facility Hinman Funeral Home M00295 Ave., Princess Anne, MD 21853 11673 Somerset Approximate Interval Between Onset and Death Nat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Part1. Enter the disease, or complications shock, or heart failure. List only one cause mediate Cause (Final ancreamo disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 5 Other (specify) 1 □ Yes 2 ☑No 9 Dluknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 □No 1 □Yes 2 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

show

Director

Funeral

2

Completed

Be

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d other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be ricitlisd at

permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 1 and Injury or other traumatic event, It. Marical Evan Incl. mast be in once.

the Maryland

Records, P.O. Box 68760,

Division of Vital

Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit is certificate has been s director, page 2 should

Physician/Medical ģ Completed Be

Certification: To

Medical

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifia

State Registrar 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Date of Injury (Month, Day, Year)

5 Pending investigation 6 ☐ Could not be determined

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License numbe

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Milford 32. Registrar's Signature 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month 06 0^{Ye ar} **Physician** Pay 14 0545 M William Murphy /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** ALLEGANY WMHS BRADDOCK CAMPUS CUMBERLAND 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Aug 28, 1919 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ F Months Days Hours Min. 083-07-9001 89 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It of Mexical Examinational Resolution once. MD Allegany Cumberland 1 □ Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 901 Seton Drive 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. If Yes, Give Year or Dates: Specify: þ 3 Widowed 4 Noivorced white Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Unknown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12 Cresent Place Cumberland MD 21502 19a. Informant's Name/Relationship (Type. Print) friend Cathy Izat 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/18/2009 Rocky Gap Veterans Cemetery Flintstone MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility all Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part1. Enter the dise se or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Candiovascular **Physician** /Medical Due to (or as a consequence of) Examiner Se puentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a □Yes 2□No detached Ö 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform certificate 1 ☐Yes 2 No 2. No 1 □ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier nonsockosh 00055325 June 14, 2009

Registrar
DHMH 17 Rev 1/2001

Dr

State

WONSOCK

31. Date filed (Month, Day, Year)

Rd Camberland MD21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUN 1 9 2009

925 Bishon

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 31 2009 **Physician** 10:34 PM Mary Virginia Peacock May /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facilify Name (If not institution, give street and number) Examiner Anne Arundel Edgewater 137 Wallace Manor Road 8. Date of Birth (Month, Day, Year) July 11, 1959 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Days Hours Months 214-62-1460 1 □ M 255 49 Maryland Director Usual Residence of Decedent 10c City, Town or Location 10d. Inside City Limits 10b. County 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Edgewater 1 ☐ Yes 2 XNo Maryland Anne Arundel Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21037 137 Wallace Manor Road Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 35 No If Yes, Give 11 Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married White 1 ☐ Yes XXNo altimore, Maryland 21215-0036 2 Year or Dates: 3 □ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than 'any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) F.B.I. Program Analyst 12 18. Mother's Name (First, Middle, Maiden Surname, Mary Lee Christenson 17. Father's Name (First, Middle, Last) Be Robert V. Peacock 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Richard Sickels/husband 137 Wallace Manor Road Edgewater, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 6/3/2009 Baltimore Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature en leral Servior Licensee 147 Duke of Gloucester St., Annapolis, MD 21401 00 23a. Part1. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to infunediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 1 ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be det þ 1 | Yes 2 No 3 | Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autonsy performed? Yes 2 No 1∏ Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director, p 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3□ D0A Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 datural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours aft To the Funeral DI completely filled in Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State

To the

31. Date filed (Month, Day, Year) **JUN 03** Registrar

29b. Signature and title of certifier

900 Best- cité Registrar's Signature 32.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

R1 Ste 300

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Marian Ade Poge 2, 2009 8:07 a M June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince Georges Hospital Center Prince Georges Cheverly If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 1 F 65 Yrs 217-44-7675 07/08/1943 Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County show Examiner must be notified at D. C. X Yes 2 No Washington Director 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 23a 5000 Nannie Helen Burrough Ave., N.E. 20019 U. S. A. Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc hours after 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐Yes 2x No Specify Specify: Black ş 3 Widowed 4 Divorced "natural", Completed 16b. Kind of Business/Industry event, the Mudical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 72 (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) St. Gabriel 10th Day Care Worker 12 should be filed with and Mental Hygie 7 Is marked other t filed \ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter William Poge Daisy Yarbrough ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20747 Health tem 27 Floyd Randolph Poge (Brother) 6507 Pennsylvania Ave., #101 District Hgts. Md. item 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages nent of I Department of Important: If it any Injury or o 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Chesapeake Crematory 06/05/2009 Beltsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) gnature Funer Servi Licensee W. H. Bacon Funeral Home, Inc. 3447 14th Street, N. W. Washington, D.C. 20010 Pair /Enle/the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Importe Cause (Final discrete or condition resulting in death) **Physician** Hypertensive Cardiovascular Disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any leading to minerial cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Directo for as a consequence off burial-transi and resulting in death) Last Due to (or as a consequence of) Box 68760, nding physician requires that the death certificate be Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? atter for u 3 Ectopic pregnancy Day Year Month 5 ☐ Other (specify) ped ☐Yes 2 No o the 9 Unknown 9 Unknown ned by 1 ₫. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The law has autopsy performed? certificate Encephalopathy 1 □Yes 2X No 1 ☐Yes Division of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No ၉ 1 M Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred e Hospital or Attending P 124 hours after death. e Funeral Director; After t letely filled in by the funera After Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after des re Funeral Directo 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Death occurred at the time, date and place, and due to the cause(s) and manner as stated. Death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) rination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the within 2 To the completed 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number June 4, 2009 D 31528 30. Name and address of person who completed Margaret Akhan, M. cause of death (Item 23a) (Type, Print)

3001 Hospital Drive D. Cheverly, Md. 20785 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 0 8 2009

DHMH 17 Rev 1/2001

Registrar

			1 - State Registrar	F		78	Cer	tificate c	of Death	7		Reg. No.		
			1. Decedent's Name (First, Middle	e, Last)							2. Date of Dea	ath Da <u>y</u>	Year	3. Time of Death
	Physicia /Medic		Joyce N. Pos	t							June	3	2009	1708 M
	Examin		4a. Facility Name (If not institution	n, give street a	and number	7)		4b. City, Town	n, or Location	of Death		4c.	County of Deat	n
and t			PENIDSULA KEGIO		ledico		TER	Sal	sbun				Wicom	1 CO
	Funeral Director		5. Social Security Number / 900-30-8571	6. Sex		ige (In yrs. la 70	ast birthday) Yrs.	If Under 1 Ye Months Da		Min.	8. Date of Birt (Month, Da 05/14/	n 1939	New	nplace (State or Foreign untry) Jersey
	ס		Usual Residence of Decedent											40.11.11.00.11.11
	rylan show	_	10a. State 10b. County			10c. City	, Town or Loc	eation						10d. Inside City Limits 1 ☐ Yes 2 ▼ No
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	ith th	Dire	10e. Street and Number					10f. Zip Coc				10g. Citi	zen of What Co	untry?
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	er de Items	Funeral Director	11. Marital Status	Arı	as Deceden med Forces ∐Yes 2⊠		s. 13. V	Vas Decedent Yes, specify (of Hispanic C Cuban, Mexica	an, Puerto F	Rican, etc.)	-	 Race - Ame Black, White 	
0000	be filed within 72 hours after death with the Maryland tial Hygiene. d other than "natural", or items 23a or 28a-f show event, I'm Moden Examiner must be notified at	b	1 ☐ Never Married 2 🙀 Mar 3 ☐ Widowed 4 ☐ Divorced	If Y	es, Give ar or Dates		1	□Yes 2【X	No Specif	y:			Specify: Wh	nite
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7	thin 7 le.	ם	(Specify only higher Elementary/Secondary (0-12)		ollege (1-4or	5+)	life. D	OO NOT use re	tired)		9	-	a .	
7	filed wi Hygien ther th	ပ္ပ်	12				Scho	ol Bus					Contra	ctor
	~ = 0 8	Be	17. Father's Name (First, Middle, Raymond Dre							ner's Name Rose P	(First, Middle,	Maiden	Surname)	
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N N	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any Injury or other traumatic enone.		19a. Informant's Name/Relations Martin E. Post/		intj								4D 21830	
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			23a. Part 1. Enter the disease, o shock, or heart failure. List	r complication t only one cau	s that causes se on each	ed the death line.	. Do not ente	er the mode of	dying, such a	as cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition		epers									Onset and Death
	/Medical Examiner		resulting in death)		Due to (or a	s a consequ	ence of):							
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	execu n and al-tra	Examiner	that initiated events resulting in death) Last	С	Due to (or a	ıs a consequ	ience of):							
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Ţ.	hat th		Part II. Other significant condit	ions contribut	ing to death	but not resu	ulting in the ur	nderlying cause	aiven in Par	t I.	23e. Did	tobacco	use contribute to	the cause of death?
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Ď	ne lav e has ge 2	Completed									auto perfe	psy ormed2	prior to	completion of cause of
Z Z	in: Ti tificati or, pa		25. Was case referred to medica	al					26 Pla	ce of Death	1 ☐ Yes (Check only	one)	o 1∐Yes	s RENO
>	ysicia s cer direct	To Be	examiner? 1 ☐ Yes 2 ☐ No	Hospita	al: 🔀 Inpa	ıtient 2 □	ER/Outpatier	t 3 DOA	Other:				6 ☐ Other (Spe	ecify)
0	ter thi		27. Manner of Death Natural 5 ☐ Pendi	28	a. Date of Ir (Month, I	njury Day, Year)	28b. Time of Injury	28c.	Injury at Work?		28d. Describe	how inju	ry occurred	
<u> </u>	endir sath. or: At	atic	2 ☐ Accident Invest	tigation					1 □ Yes 2 [
UNISION	or Att fter de directe in by t	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deterr	mined 286	e. Place of I building,	njury - At ho etc. <i>(Specif</i>)	ome, farm, stro y)	eet, factory, off	ice		28f. Location (City or To			ural Route Number,
_	pital ours a eral ceral ceral		29a. Certifier 1 Certify	ing Physician	To the he	st of my kno	wledge deat	n occurred at t	ne time, date	and place	and due to the	e cause(s	s) and manner a	s stated.
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	(Check only 2 Medica	l Examiner: 0	On the basis	of examina	tion and/or in	vestigation, in	my opinion, d	leath occurr	ed at the time	, date an	d place, and du	e to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certific	er					cense numbe	r		29d. Da	ate signed (Mon	th, Day, Year)
	Ω'		> hall	- ^,				D	63199			06	/65/2m	1.
	Van		30. Name and address of persor	n who complet	ted cause o	f death (Item	1 23a) (Type,	Print)	_ /	1				
	0		YogEsh VohRA	7 mD	100	E. CA	ARROLL	51. 5	PALISI	buny.	md o	1180		
	Sta Registr		31. Date filed (Month, Day, Year	8 2009	32. Hogis	strars Signa	ture	Print)						
	3,01		JUNI	O KAND	1		P. 18							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Douglas C. Reynolds 30 **Physician** May 2009 7:00 A M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Severna Park 241 McKinsey Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, Year **Funeral** Months Days Hours 1 M 2 □ F 82 214-22-9324 18,1926 North Carolina Aug. Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show ? Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Wedical Exertiner must be multified at 1 ☐ Yes 2 ☑ No Anne Arundel Severna Park Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene. USA 21146 241 McKinsey Road Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Tyres 2 □ No WWII If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 Specify ⋛ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Chief Electrician Newspaper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Brattie Elliott Henry Earl Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 241 McKinsey Road Severna Park, MD 21146 Health a Isolde Reynolds / Wife Item 27 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition June 02, Department of Important: If It any Injury or conce. 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery Crownsville, MD Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 21. Signature of Furneral Service Licensee 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of lying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RCIVS Physician /Medical Due to (or as a conseque e of) Star Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 □Yes 2 □No is certificate has been signed by the director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 2 No 5 Residence 6 □ Other (Specify) 1 ☐ Yes 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Deal After Natural 5 ☐ Pending investigation n 24 hours after death.

Pe Funeral Director; Afte bletely filled in by the fun 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely within 2

2

2009

29b. Signature and title of certifier

JUN 02

29c. License numbe

29d. Date signed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 4a. Facility Name (If not institution, give street and number) 5:15 AM 2009 /Medical MAY 31 4c. County of Death 4b. City, Town, or Location of Death Examiner Worcester Nuesing Kehabilitation Center Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Min 1 ☐ M 2 🕻 F 213-22-8442 Director 11/32/1923 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 Yes 2 No a or 28a-f sh be notified Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **23a** US A 21811 other than "natural", or items 23a Completed by Funeral Way Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race · American Indian, Black, White, etc. 11 Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: African Homerican 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SUF House 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked c Annie UNK မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AlVID Salisburg NO O. Box Keue or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Gifts Ignature of Fun ral Service Licensee 22. Name and Address of 917 W. Isbella Smith tuneral Home MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** disease or condition /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) ☐Yes 2 100 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>≽</u> 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □ Yes ours after death.

leral Director: After this certific filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 T JX 1 ☐ Yes Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 [D Natural Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral D To the Hospital 29a. Certifier I Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Year) egistrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) . 20<u>09</u> Month 6, 4:15 AM Ella Marie Showers 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Washington Autumn Assisted Living Hagerstown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Months 1 □ M 2 🛛 F 90 12,1918 West Virginia 215-10-6026 November Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 XYes 2 No Hagerstown Washington Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21742 U.S.A. 310 Cameo Drive 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💢 No Specify Specify: White 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) John Gilbert Davis Virgie Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11120 Sulfolk Drive, Hagerstown, Maryland 21742 James Stephen Showers Son 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 20a. Method of Disposition Hagerstown Crematory 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 06-08-09 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, 21. Signature of Funeral Service Licensee -R hoel Brady Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) WEEKS FAILURE 10 Due to (or as a consequence of): DEMENTIA MONTHS. SEVERE ADVANCED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): HONTHS Due to (or as a consequence of): MONTHS MELLITUS DIABETES 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 ☐ Other (specify) 4□Pregnant at time of death 9□Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 10 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 1 No

Physician /Medical Examiner or Attending Physician; The law requires that the death certificate be executed

nding physician

After this certificate has been signed by the a funeral director, page 2 should be detached

Physician

/Medical

Examiner

Funeral

Director

show

"natural", or items 23a or 28a-f shovedical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner once.

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Director

Funeral

Completed by

Be

၉

Examiner Physician/Medical 2 Completed Be

IF FEMALE: 23b. Was decedent pregnant

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day Year)

Other: 4 Nursing Home 5 Residence 6 NOther (Specify) ASSISTED LIVING 28d. Describe how injury occurred 28c. Injury at Work?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

HAGENGROWN MD

29a. Certifier

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

HETNA

29b. Signature and title of certifier

5 ☐ Pending investigation

6 Could not be determined

29c. License number

ROAD

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

5H-2

within 24 hours after death To the Funeral Director:

filled in by

State

Medical Certification: To

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JUN 0 9

32. Registrar's Signature

[190

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

Registrar

State of Maryland / Department of Health and Mental Hygiene 2009

		•	For State of Maryland State of Maryland Registrar		tificate of L			Reg. No.		To Time of Dooth
	Physicia	an	1. Decedent's Name (First, Middle, Last) Kim Marie Smith		Ju			n Day	2009 ^{Year}	3. Time of Death 8:35 P. M
	/Medic	al			4b. City, Town, or	Location of Death	- Cure	4c. County of Death		
	Examin	er	4a. Facility Name (If not institution, give street and number) Fort Washington Hospital		4b. Oity, Town, or Education of Deman					orge's
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	h y, Year) 1960	Cou	place (State or Foreign ntry) 1.,D.C.	
힏			Usual Residence of Decedent 10a. State 10b. County 10c. City	ty, Town or Loc	cation					10d. Inside City Limits
laryla	shov ed at	'n	Tou. Gaile		ashington					1 XYes 2 No
the N	28a-f	rect	10e. Street and Number	TOLC W	10f. Zip Code			10g. Citizer	of What Cou	intry?
with	3a or st be	ΙΟ	7716 Jaffrey Road		2	0744	ŀ		U.S.A.	
s after death	ital Hygiene. od other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1		Was Decedent of Hi f Yes, specify Cuba I □ Yes 2 No	spanic Origin? (Spanic Origin? (Spanic Origin), Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		Race - Amer Black, White pecify:	
n 72 hours af	"natural ledical Ex	Completed t	15. Decedent's Education (Specify only highest grade completed)	16a. Deced (Give life. L	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of work ()	ing	[of Business/I	
withi	r thar	E O	Elementary/Secondary (0-12) College (1-4or 5+) 9th	Bus	Attendan					Schools
ב ק ק	othel	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Name				-a-m
	lith and Mental 27 Is marked o r traumatic eve	TOE	ReginaldMilford Smith, Sr.				tte Eli			
Mar)	f Health and Mer item 27 Is marke other traumatic		19a. Informant's Name/Relationship (Type. Print)		ng Address (Street					
6, €	f Health item 27 other tr		Leonard Paul Smith/Son	7716	Jaffrey	Road, Ft.	<u>Washin</u> Date	gton, 20c. Loca	Maryla tion - City or	and 20744 Fown, State
Ores 1	it of H		1 Burial 2 Cremation 3 Removal from State		sition (Name of matory or other place	1	1 /00			
Dalumor	rtmen rtant: njury		4 □ Donation 5 □ Other (Specify) H∂. 21. Signature of Funeral Service Licensee		Mem. Park					Maryland
	Department of H Important: If ite any Injury or ot once.		Jany M. Crall		^{2. Name and Address} 925 Burro					D-C-20019
4			23a. Part1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
> .	hysician /Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of the condition of the conditio	quence of):	tico	Slon	ىت	uc	V	Onset and Death
E	xaminer		Sequentially list conditions b.							
Ę	# # # # # # # # # # # # # # # # # # #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	quence of):						
of Inc	and -trans	Examiner	that initiated events resulting in death) Last C	auence of):	<u> </u>					
ָה ק מ	physician and s the burial-transit	alE								
6876U,	g phys	edical	d.							
BOX	by the attending stached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No 9 □ Unknown	tal death 3	□Ectopic pregnanc □ Other (specify) _	у		23	d. Date of de Month	ivery Day Year
J. 1	ad by detac		Part II. Other significant conditions contributing to death but not res	sulting in the u	ınderlying cause giv	ren in Part I.	23e. Did	tobacco us	e contribute to	the cause of death?
g Q	sign d be	d by					1 🗆	Yes 2	No 3□P	robably 4 □Unknown
Vital Records,	ne raw requires tria e has been signed t age 2 should be det	Completed					24a. Wa aut per 1□ Yes	opsy formed?	24b. Were a prior to death? 1 □ Yes	utopsy findings available completion of cause of
		BeC	25. Was case referred to medical			26. Place of Dea				
	G S.	To B	examiner? 1 Yes 2 No Hospital: 1 Apatient 2	☐ ER/Outpatie	III 3 DOA		ome 5□Re			ecify)
Division or Vita	nding Fi		27. Manuer of Death 1 Avetural 5 Pending (Month, Day Year) 2 Accident investigation	28b. Time of Injury	Wo	ryat rk?]Yes 2 □ No	28d. Describe			
DIVIS	2 - E	Certification:	3 ☐ Suicide 4 ☐ Hornicide 6 ☐ Could not be determined 28e. Place of injury - At he building, etc. (Special Country)	nome, farm, st cify)	treet, factory, office		28f. Location City or T	(Street and own, State)	Number or R	ural Route Number,
4	To the nospita or Attending Fill within 24 hours after death. To the Funeral Director. After the completely filled in by the funeral	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kn 2 Medical Examiner: On the basis of examinand manner stated.	nowledge, dea nation and/or i	th occurred at the t nvestigation, in my	ime, date and place opinion, death occ	e, and due to thurred at the time	e cause(s) a e, date and	and manner a place, and du	s stated. e to the cause(s)
	Withir Comp	Me	29b. Signature and title of certifier	au		+60	46	29d. Date		th, Day, Year) _ 2009
2	4		30. Name and address of person who completed cause of death (lite A.Mirza-Alikhani, M.D. 11711	Livings	ston Road	,Ft. Wash	nington	,Md. 2	20744	
	St Regist	ate	31. Data filed (Manth 2009 ar) 32. Registrar's Sign	nature /						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Month Lee Schott Sherry 4:15p 3 2009 June 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carrol1 Carroll Hospice Dove House Westminster If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Ye March 26 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 51 216-72-9545 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location MD Carrol1 Eldersburg 1 ☐ Yes 2X No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21784 6714 Purple Martin Court 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 ∏No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 domestic College (1-4or 5+) homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marie Pearsall Ronald Swanson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6714 Purple Martin Ct., Eldersburg, MD 21784 Mr. Bernie Schott (spouse) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State All County Cremation 6-6-09 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses P.O. Box 195 Sykesville, MD

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one care of each line. P.O. Box 195 Sykesville, MD 21784 Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 2 HO 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? er significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 D No 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann f Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

/Medical Examiner certificate be executed Box 68760. Ö Division of Vital Records,

Examiner burial-tran and signed by the attending physician the detached for use as the buria Physician/Medical þ Completed cate has page 2 s certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. p Be Certification: To Medical

Physician

/Medical

Examiner

Funeral

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28a-f show

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1 and 2 should be filed within 72 hours after death with the Maryla Heatilt and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show ther traumatic event, It is "hadical Examiner mast bornallind a

permit. Pages 1 and 2 s
Department of Health at
Important: If item 27 is
any Injury or other trau

Physician

Pages 1

Baltimore, Maryland 21215-0036

SL

and manner stated. 29b. Signa

29c. License number 5 3 9 2

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

Street WESTLINSTER, 40 2115 31. Date filed (Month, Day, 32. Registrar's Signature

State Registrar

29a, Certifie

use as the burial-transit P.O. Box 68760 the attending physician Division of Vital Records. After this

Baltimore, Maryland 21215-0036

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5 Year **Physician** Snowder 8:40pm enee /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical Annapolis Anne Arundel Arundel Center If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗖 F Months 19/4/9/19 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a constants any injury or other traumation. 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 Yes 2 □ No Director nna polis 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States McKinley Street 21403 Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Black Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/AN/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Snowder lacole Wallace ဥ en 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kenya Wallace MOther 1310 McKinley Street Annapolis MD 21403 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 5/27/09 Glen Burnie, MD 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Son of Licensee 22. Name and Address of Facility Hardesty Funeral Home P.A. 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Severe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events on this is death), act Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🖼 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ∐Yes 2 **X**No 1 □ Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 → Apatient 2 □ ER/Outpatient 3 □ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rindfleisch Medical Zanhe 2001 31. Date filed (Month, Day, Year) 62. Registrar's Signature State JUN 01 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) EELIG FELTON Ol 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Mandrin Chesapeake Hospice House Harwood Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 12/03/1928 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Days Hours 12 M 2□ F Texas 80 450-38-7245 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 1 Nes 2 No Loudoun Sterling Virginia 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20164 4 Darus Court 14. Race - American Indian, 12. Was Decedent Ever in U.S. Agned Forces? 1⁄2] Yes 2 □ No If Yes, Give Year or Dates: 1946-76 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Military Master Sergeant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Tony Meta Dornbuch Otto August Seelig 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4 Darus Court, Sterling, Virginia 20164 Pamela D. Froelich/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Kalas Crematory 05/29/2009 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Fymeral Service Licensee 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each man. Immediate Cause (Final disease or condition resulting in death) Willin Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

burial-transit

the Hospital or Attending Physician: The law requires that the death certificate be executed

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Records. P.O. Box 68760.

Division of Vital

Completed by Physician/Medical Examiner

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Department of Important: If it any injury or o

Physician

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental hygiene.
ant: If item 27 is marked other than "natural", or items 23s or 28s-f show ury or other traumetic event. If we Medical Examinat must be notified at

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

24a. Was an autoosy perform 1 Yes

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

Hospice

25. Was case referred to medical examiner? 1 □ Yes 2 No 27. Manner of Death 1 Natural 5 ☐ Pending

2 Accident

4 \ Homicide

3 🗍 Suicide

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

32

28b. Time of

Other: 4 Nursing Home 5 Residence 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

investigation

determined

6 Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d Date signed (Month, Dav. Year)

6 ther (Specify) House

State Registrar

31. Date filed (Month, Day, Year) JUN 01 2009 Registrar's Signature

impleted dause of death (Item 23a) (Type, Print

		For	State of Maryl				Mental Hyg	giene		20
		State Registrar		Cei	rtificate of	Death		Reg. No.	9 1980	36
Physic	cian	1. Decedent's Name (First, Middle Charles Alber					2. Date of Dea Month May	Day \	3. Time of De 8:35 P	
/Med Exami		4a. Facility Name (If not institution			4b. City, Town, o	r Location of Death		4c. County of	Death	
LAUITI		310 Balsam D	rive		Seve	rna Park		Anne	e Arundel	
Funera Directo		5. Social Security Number 218–26–4461	6. Sex 1 X M 2 □ F 7. Age (In)	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day July 1	h y, Year) 4,1931	9. Birthplace (State or Fo Country) Maryland	oreign
and w		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City L	∟imits
Maryle f sho	jo		Arundel	Severna					1 □Yes 2	
h the	ìrec	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	l nat Country?	
23a c	ral	310 Balsam D	rive		2114	16		USA	L	
DESILLINOTE, INIGITY IBING 21213-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ira I safeti Eveninar manta notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Marri 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 MYes 2 □ No If Yes, Give Kor Year or Dates: War		Nas Decedent of H fYes, specify Cuba I∐Yes 2⊠No	lispanic Origin? (S an, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	o- 14. Race - American Indian, Black, White, etc. Specify: White		
5-UU36 72 hours aff natural", or	sted	15. Decedent (Specify only highes	s Education	16a. Deced	dent's Usual Occup	ation during most of won	kina	16b. Kind of Busi	ness/Industry	
/ithin	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use retired	d) -		Donostmo	nt of Dofor	200
Illed w Hygie ther th	S	17. Father's Name (First, Middle, I	ast) 4	S	ystem Ar			Departme	ent of Defer	ise
yiand ould be file Mental H arked oth	To Be	Charles A. Sea	,				L. Willi			
ary shou and M s mar	-	19a. Informant's Name/Relationsh				and Number or Ru				
and 2 lealth m 27 i		Ethel M. Sears				orive Se			.,-	
Dallimore Dermit. Pages 1 Department of H mportant; If ite tny Injury or ott		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.	3 □ Removal from State H		Memoria Cemetery	June	Date 2009	Annapol		
Dal permit Depar Impor any In		21. Signature of Fundral Service I	icensee	B2	Name and Addre	ss of Facility P.	A. Seve	rna Park	Funeral Ho	me
		23a. Pirt1. Enter the disease, or	complications that caused the d				-		, MD 21146 Approximate	
Physician		shock, or heart failure. List of Immediate Cause (Final	only one cause on each line.	ducal	achi		1.33		Interval Betwee	ath
/Medical		disease or condition resulting in death)	a. Due to (or as a cons	sequence of):	7311	Synd	One		3 year	<u> </u>
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Physician: The law requires that the death certificate has been signed by the attending I director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	Ectopic pregnanc Other <i>(specify)</i>	у		23d. Date Mont	of delivery th Day Yea	ar
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Atter er dea ector by the	Certification:	3 Suicide 6 Could n 4 Homicide determi		t home, farm, stre	eet, factory, office		28f. Location (S City or Tow	Street and Number	r or Rural Route Number	Γ,
italo ral Di	Cer									
To the Hospital or Attending Profile 20 within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	ledical	29a. Certifier 1 Medical E	Physician: To the best of my xaminer: On the basis of exan and manner stated.	sination and/or in	actigation in my a	minion double occur	read at the time.	data and place ar	ad due to the causea(s)	
To the within To the compl	Me	29b. Signature and title of certifier			29c. Licens	e number	:	29d. Date signed	(Month, Day, Year)	
axla	1	Jeenen	weing n	P	DS	2830)	may Z	9,200	7
Rot	V	30. Name and address of person v	who completed cause of death (Item 23a) (Type, I	Print)	e Prodi	#300	Annero.	(Month, Day, Year) 19, 200	unl
St	ate	31. Date filed (Month, Day, Year)	32. Pegistrar's Si	gnature	3, g=1	Consul		11100	· · · · · · · · · · · · · · · · · · ·	TUI
Regist	rar	JUN 02	2009 Jenus	B. A.	and	_				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 10:35 P ^M 30 2009 May Paul Skreptack /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel South River Health & Rehab. Center Edgewater If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number Hours **Funeral** Months 1 X M 2□ F June 28,1923 Pennsylvania 204-12-9095 85 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventment and the market be marked. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 X No Director Owings Maryland Calvert 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20736 975 Cat Bird Lane by Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 MYes 2□NoRetired
If Yes, Give
Year or Dates: 1964 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🎇 No Baltimore, Maryland 21215-0036 Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Air Force Personnel Administrator 12th 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Eva Arecluk Paul Skreptack ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 975 Cat Bird Ln., Owings, Maryland 20736 Susan Skreptack/ Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Arlington National Cemetery 8/19/09 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Furteral Service Licensee 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and the detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year Day 5 Other (specify) I ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has birector, page 2 sl autopsy performed? Yes 2 12 No 1 ☐ Yes 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 1 - Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 5851 Deale Churchton Rd., Deale, MD 20754 Gyan C. Surana, M.D. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State **JUN 02** Registrar

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DHMH 17 Rev 1/2001

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State Registrar 29b. Signature and title of certifie

12016 31. Date filed (Month, Day,

f prson who completed cause

Year)

death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Paul Edward Summers, Sr. 11, 10:55P M 2009 June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13934 Greencastle Pike Hagerstown Washington Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min **½**□ M 2□ F Director 234-42-3496 80 West Virginia Sept. 13, 1929 Usual Residence of Decedent 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2√☐ No Md. Washington Hagerstown filed within 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13934 Greencastle Pike 21740 U.S.ACompleted by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☑ Married ty∏Yes 2 ☐ No If Yes, Give Year or Dates: Maryland 21215-0036 r than "natural", or i 1 ☐ Yes 2 → No Specify. 42-45-White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Stell Worker Fabricator other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) in and 2 should be fill.

Health and Mental H
tem 27 is marked oth Be Frank Summers Clara Brock traumatic ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13934 Greencastle Pike Hagerstown, Md. 21740 Paul E. Summers Jr. (Son) : If item 27 or other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 permit, Pages
Department o
Important: If i
any Injury or 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State June 13, 4 □ Donation 5 □ Other (Specify) Smithsburg Crematory Smithsburg, Md. 2009 Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. MO1414 J.L. Davis Funeral Home Smithsburg, Md. 21783 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Non-small cell lune cancer months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medicai the IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) the detached 9 Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 □Yes 2 No neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury death. investigation M 2 Accident 1 ☐ Yes 2 ☐ No 3 Sulcide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and tipe of certifier

31. Date filed (Month, Day, Year)

Scott A Wegner

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

32. Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

11/10 medical Compan Ka #130

phen G. Tho		State 1- For State Registrar	e of Marylan		tment of ficate of		Mental Hy		eg. No.	2	009	9 198
Physici	an/	Decedent's Name (First, Middle, La	ast)					Date of Deat Month	_	Year		Time of Death
dical Exami	ner	Stephen Garry						June 5, 20	009	. County of		2115 hrs
		4a. Facility Name (if not institution, gi 11009 Clinton Avenue	ve street and numb	er)	4	b. City, Town, or Lo Hagerstown	cation of Death			Vashingt		
Funeral			Sex 7	Age (In yrs. last	: birthday)	If Under 1 Year	If Under 24Hrs	. 8. Date of Bir	th (MM/	(DD/YYYY)	g. Birthpl	ace (State or Foreig
Director			M 2 F	56	Yrs.	Months Days	Hours Min.	Nov. 3	0,	1952	Mary	yland
v any		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Location	on						d. Inside City Limits
land f show	ē	Maryland Washing	ton	Hage	stown							Yes 2 No
Mary r 28a- ed at	irec	10e. Street and Number				10f. Zip Code				zen of Wha	at Country	?
vith the Maryland s 23a or 28a-f show s e notified at once.	<u></u>	11009 Clinton Av			140.14	21740	ania Origina (Ca		U.S		Amorican	ı Indian, Black,
5-0036 led within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f sho the Medic I Examiner must be notified at once	Funeral Director	11. Marital Status 1 Never Married 2 Marrie		es?		Decedent of Hispa es, specify Cuban, I			1-	White,		i indian, black,
ifter d		3 Widowed 4 Divorce	1 Yes	2 No	1	Yes 2 No	specify:			Specify:	Whi	te
lours a	a pe	15. Decedent's Education (Specify	only highest grade of	completed) 1		's Usual Occupatio est of working life. D			16b.	Kind of Bus	iness/Indu	ıstry
36 in 72 h han "r	Completed by	Elementary/Secondary (0-12)	College (1-4	or 5+)	Sheet	•	70 710 7 000 700	. • • • •	,	irora	f+ M	anufactur:
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nore, MD 21215-0036 ges 1 and 2 should be filed within 72 nt of Health and Mental Hygiene. tt: If item 27 is marked other than ' other traumatic event, the Medical	Be C	Clifford Thoma	,				Frances					
MD 21, 2 should b h and Men 27 is mar	70	19a. Informant's Name/Relationship (19b. Mailing	Address (Street				City or Town	, State, Zi	ip Code)
MD and 2 shoulth and 11 is sumat		Clayton L. Thoma	s / Son			Twin Spr						
S I BE OF HER		20a Method of Disposition 1 Burial 2 Cremation 3	Removal from	State 205. Pla	ace of Disposi ematory or oth	tion (Name of ceme er place)	etery,	Date	20C.	Location -	City or 10	wn, State
Baltimore, bermit Pages 1 ar Department of Hee Important: If ite		4 Other Specific	Y: _		Haven	Cemeter	y 6/	13/2009	Hay	gerst	own,	Maryland
Baltimore, MD 2 permit Pages 1 and 2 shoul Department of Health and N Important: If item 27 is n injury or other traumatic		21. Single ure of Funeral Service No.	nsee									pel 21742
Physician		23a. Part I. Enter the disease, or com	aplications that caus	sed the death. D	1 16 o not enter th	01 Penns	y I van 1a uch as cardiac c	AVE . Ha	age: est, sh	ock, or hea	n, Ma	Approximate Interva
/Medical		failure. List only one cause on a	each line. _{a.} Contact Guns	shot Wound	of Head							Between Onset and Death
xaminer		or condition resulting in death)	Due to (or as a co		0111000							
	Ļ.	Sequentially list conditions,	Due to (or as a co								-	
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sd sit	Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a co	nsequence of):								
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Box 6876(the death certificate the attending phy: hed for use as the b	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth	1	2 Fet	al death 3	Ectopic pregna	ancy	1	Month	Day	/ Year
OX (sici	1 Yes 2 No 9 Unknow		t at time of deat	h 5 Oth	ner (Specify)			Î			
D. B.	Phy	Part II. Other significant conditions			ulting in the u	nderlying cause giv	ven in Part I.	23e. Did t	obacco	use contri	bute to the	e cause of death?
ires that the signed by	d b							1 Ye	s 2	√ No 3	Probat	oly 4 Unknown
of Vital Records, g Physician: The law require the this certificate has been signer this certificate of the control of the con	Completed							24a. Was				osy findings available
eco ne law te has ge 2 si	dmo							perfo	ormed? 2 ✔ I	ď	eath?	2 No
tal Reco		25. Was case referred to medical				26.Place o	of Death (Check		2 🔻	<u> </u>		
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ion of Vital F tending Physician: eath. or: After this certifi the funeral director,	n: T	27. Manner of Death	28a. Date of FOUND:	Injury 2 ay,Year)	28b. Time of Ir			28d. Describe Subject sho			ed	
Attendi r death. rector: by the f	atio	1 Natural 5 Pending 2 Accident Investiga	I E 000		FOUND: 2111 hrs	1 Ye	es 2 🗸 No	-				
`> ₽ ₫ ij ij	Certification:	3 ✓ Suicide 6 Could no determin	ot be			t, factory, office bu	ilding, etc.	28f. Location (or Town, \$ 11009 Clintor	State)			Route Number, City
[E G E E		29a. Certifier Certifying Physi	ician: To the best o	Single Famil f my knowledge	, death occur	red at the time, date	e and place, and	d due to the cau	se(s) a	nd manner	as stated	
To the How within 24 h To the Fur completely	Medical	one) 2 Medical Examin	er:On the basis of e and manner state	examination and ed.	I/or investigati			at the time, date				
0	Σ	29b. Signature and title of certifier	000			29c. License						n, Day, Year)
45		Tate L	- Toll	el py	2	O.C.N	I,E,		Jui	ne 6, 200	<u>.</u>	
5×1		30. Name and address of person who Patricia Aronica-Pollak M		of death (Item 2 t Medical Ex		111 Penn Str	eet. Baltimo	re. MD 2120)1			
	tate	21 Date filed (Months Con Months)	22 Pagis	strar's Signature			Joi, Daillino	. 5, 1110 2120				
Regis		2.	and Lon	wa p		Kel						<u> </u>
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 615 AM 06 **Physician** avil Thomas /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner -I-I (more If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7, Age (In yrs. last birthday) **Funeral** Months Days Hours 1 XM 2 □ F 88 Director 214-12-3929 11/24/1920 PA Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b County or items 23a or 28a-f show traumatic event, if a Medical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director FI. PINELLAS CLEARWATER 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 2451 CANADIAN WAY APT. 3 33763 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Was Decedon Armed Forces? 1 ☐ Yes 2 XNo permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any injury or other traumatic event, Ite Modical Examinations. Black White etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 2 3 X Widowed 4 □ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) INDUSTRIAL ENGINEER STEEL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DAVID THOMAS MARGARET ANN WALTERS ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) PHILLIP S. THOMAS ARROWSHIP RD. DUNDALK, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION: 6/10/09 STEVENSVILLE, MD 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 21. Signature of Funeral Service Licensee 130 SPEÉR RD. CHESTERTOWN, MD 21620 Approximate Interval Between Onset and Death 23a. Int 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): N3 WEKS **Examiner** U Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ect in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 ☐ Pregnant at time of death (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>6</u> 2 No 3 Probably 4 Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t 10 36,3 5 Pending investigation 1 Natural hall Down 2009 1 ☐ Yes 17 MKnown 24 hours after death. 2 Accident 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

South

32. Regintrar's Signature

St.

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene [] [] 9 Certificate of Death

3. Time of Death

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5:00

Reg. No.

2009

2. Date of Death

Month JUNE

Physician
/Medical
Examiner

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

MARGARET G. TAYMAN

Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Modical Examine trunst be rediffed at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Sta

		give street and numbe	er)	4	b. City, Town, o		Death		4c. County		
	HEARTLAND HOUSE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda				GRASONV f Under 1 Year		QUEEN ANNE S 9. Birthplace (State or Foreig				
579-01-03	321	1 M 2 X F	92		Months Days		Min. MARC	of Birth th. Day Ye H 27	1917		ABAMA
Usual Residence of	f Decedent 10b. County		10c City To	own or Locat	ion				10d Inc		
		ANNE'S	100. Oity, 10								10d. Inside City I
MARYLAND		ANNE 5		CHEST							
10e. Street and Nur					10f. Zip Code			10g.	Citizen of V	What Cou	untry?
1336 CAI	LVERT ROA	AD			21	619			UNITE	D ST	ATES
11. Marital Status		12, Was Deceder Armed Forces	nt Ever in U.S.	S. 13. Was Decedent of Hispanic Origin? (Specity Yes or No- If Yes, specity Cuban, Mexican, Puerto Rican, etc.)						e - Amer k, White	rican Indian,
1 ☐ Never Marr 3 🛣 Widowed	ied 2□ Married 4□ Divorced		No		Yes 2 No	Specify:		,		/: W H	
(Spec	15. Decedent's l	Education	10	6a. Deceden	it's Usual Occup of of work done	ation during most o	of working	16b	. Kind of Bu	usiness/l	ndustry
Elementary/Seco	ondary (0-12)	College (1-4o	r 5+)	life. DO	NOT use retired MEMAKER	1)			OWN I	HOME	
17. Father's Name	(First, Middle, La:	st)	•			18. Mother's	s Name (First, N	liddle, Maid	den Surnan	ne)	
SAMUEI	L LAWREN	CE GREGORY	•			MYRT	TIE IREN	E YEA	KEY		
19a. Informant's Na	ame/Relationship	(Type, Print)	1	9b. Mailing A	Address (Street	and Number	or Rural Route I	Number, Ci	tv or Town.	State, Z	(ip Code)
JUDITH WE		, , ,		•	,		NSTOWN,				
20a. Method of Dis	-	TOGHTER		of Disposition							Fown, State
1 ☐ Burial 2 l		Removal from Stat	e CHES?	APEAKE CENTE	°'CREMAT		UNE ^{D3} 5, 2009	- 1		-	E, MD
21. Signature of Fu	ineral Service Lic	ercae	D	FEI 106	LOWS, E	ELFENE CK ROA	BEIN & N	EWNAM TER.	FUNE	RAL 619	HOME, P.
		mplications that causely one cause on each		o not enter t	the mode of dyir	ng, such as ca	ardiac or respira	tory arrest,			Approximate Interval Betwee Onset and Dea
Immediate Cause disease or condition resulting in death)	on .	_a. 1/16	olm 615								
resulting in death)	•	Due to (or a	is a consequenc	ce of):							
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Sequentially list co- if any, leading to im- cause. Enter Unde	mediate	Du- to or a	is a consequenc	ce of):							
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resulting in death) I	Last	Due to (or a	is a consequenc	ce of):							
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IF FEMALE:									1		
23b. Was deceden		23c. If yes, outcom 1 ☐ Live hirth	ne of pregnancy 2 Fetal dea		ctopic pregnanc	V				te of deli	
in the past 12 1 ☐ Yes 2			at time of death		ther (specify)	,			Mo	onth	Day Yea
9 🗆 Unknown		9 LI ONKNOWN	1								
Part II. Other signif	licant conditions	contributing to death	but not resulting	g in the unde	rlying cause giv	en in Part I.	23e.	Did tobac	co use cont	tribute to	the cause of dea
								1 Z Yes	2 🗌 No	3 ☐ Pr	obably 4 ☐ Unk
!							24a	Was an	24h	Were au	topsy findings ava
the Add of							- -	autopsy		prior to death?	completion of caus
		7					10			1 □Yes	2 □ No
25. Was case refer examiner?	_	Hoenital			Oth		f Death (Check	only one)			
1 ☐ Yes 2 🔀	-	The state of the s	tient 2 ER/			4 M IVUIS	sing Home 5			- ' '	cify)
27, Manner of Deat 1 Natural	th 5 ☐ Pending	28a. Date of Ir (Month, E	njury 28t D <i>ay, Year)</i>	o. Time of Injury	28c. İnjur Worl	y at </td <td>28d. Des</td> <td>cribe how i</td> <td>njury occur</td> <td>red</td> <td></td>	28d. Des	cribe how i	njury occur	red	
2 Accident	investigati					Yes 2□No					
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not determine	Zee. Place of I	njury - At home, etc. <i>(Specify)</i>	farm, street,	, factory, office		28f. Loca City	tion (Stree or Town, S	t and Numb tate)	er or Ru	ıral Route Numbe
20n Cortifier		Physician: To the bes aminer: On the basis and manner:	of examination								
29a. Certifier (Check only one)	l siste of a matified	, , 1/1	1	/	29c. Licens	e number		29d	Date signe	d (Month	h, Day, Year)
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(Check only one)	el //-	MUKA	en		100	270	255		6/4/	200	7.9
(Check only one) 29b. Signature and	elH.	o completed cause of				270	155		6/4/	200	29
(Check only one) 29b. Signature and	ress of person wh		death (Item 23)			270 sonvil	255 le, Md.	21638	<i>4/4/</i> 3	200	7.4

DHMH 17 Rev 1/2001

Registr

State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 200^{Year} Month **Physician** 5:00pM June 3 Gillespie Tenor Terri Lynn /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Fort Washington Fort Washington Health&Rehab If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/23/1959 Birthplace (State or Foreign
Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days **Funeral** Hours Months 1 □ M 2 X F WashingtonDC 578-90-5550 50 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-1 show other traumatic event, the Mudical Examiner must be notified at 1 Yes 2 No Director Prince George's Clinton MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 IISA 7607 Castle Rock Drive 20735 or Items 23a death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Food Service Private 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Florence Griffin Israel Gillespie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is rr eny injury or other traum QDCE. 410 Prarie Ct. Upper Marlboro, MD. 20774 Florence G. Long/Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 06/08/09 Suitland, MD Lincoln Cemetery ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Briscoe-Tonic Funeral Home 21. Signature of Funeral Service Licenses -/One 2294 Old Washington Rd. Waldorf, MD. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Advanced H.I.V. Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Que to for as a consequence of Examiner certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician P.O. Box 68760 Physician/Medical as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year in the past 12 months? Month Day jo 5 Other (specify) 4□Pregnant at time of death 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Feeding dysfunction been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Wasting Syndrome page 2 autopsy perform 1 ☐ Yes 2 ☐ No 1 Yes 2XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After the Hospital or Attending 5 Pending investigation 1 Natural 2 Accident 1 ∏ Yes 2 ∏ No Director: 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated within 2 To the 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of entifier June 5, 2009 D42955 16 30. Name and address of person who completed cause of death (frem 23a) (Type, Print) Edger Potter, 11701 Livingston Rd. #207 Ft. Washington, MD. 20744 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUN 0 8 2009

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 1445 PM **Physician** ine 2009 ALBERT AUGUSTUS WILSON /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner laby Easton Memorial Hospital | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | OCTOBER 2,1920 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Social Security Number **Funeral** Days 1**X** M 2□ F Months DELAWARE 88 222-10-3535 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hinry or other traumatic event, Ital Medical Experiment is not the continued once. 1 X Yes 2 □ No Director QUEEN ANNE'S CENTREVILLE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21617 122 HAMMOND ST. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status rmed Forces? XYes 2 ☐ No Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates 1942—1945 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 K No Specify: Specify: WHITE 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) TOOL & DIE MAKER MANUFACTURING 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **NELLIE MYERS** ROBERT WILSON 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 122 HAMMOND ST., CENTREVILLE, MD 21617 PATRICE BECK/GRANDDAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place)
DELAWARE VETERANS 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State JUNE 9, 2009 BEAR, DELAWARE 4 ☐ Donation 5 ☐ Other (Specify) CEMETERY 21. Signature of Funeral Service FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Coronar **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence f): Examiner Conger if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 5 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral or 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c license number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death them 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2009 Registrar A. park

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🤈 🖺 🗎

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1 - State Registrar Certificate of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 **Physician** 7:20 A M JUNE 4. DAVID PHILLIP WHITBY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner QUEEN ANNE'S CENTREVILLE HOSPICE CENTER OF QUEEN ANNE'S If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7/14/1952 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Months Hours Days 1 X M 2 □ F **Director** 219-60-1361 Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, its Medical Evariner must be notified at 1 ☐ Yes 2 No Director QUEEN ANNE'S QUEENSTOWN MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21658 114 NASH DR. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐XNo If Yes, Give 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 💹 No Specify Specify: à 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) SEAFOOD WATERMAN 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BETTY JANE STEVENS SAMUEL PHILLIP WHITBY 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any injury or other trae DEBORAH WHITBY/WIFE 114 NASH DR. QUEENSTOWN, MD 21658 20b. Place of Disposition (Name of CHESAPEARE CREMATION CENTER 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 106 SHAMROCK ROAD, CHESTER, MD 21619 Approximate Interval Between Onset and Death 2 1/3 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Prostate Carcin **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-transi resulting in death) Last Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical as IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) ☐Yes 2☐No signed by the a Ö 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐Yes 2 ☐No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending P within 24 hours after death.

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Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

2981

MD

c. Halvoson

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3	/Medic Examin		4a. Fecility Name (If not institution, gir	e street and num	ber)		4b. City, Town, o	Location of C		4c. Coun	ty of Death	
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	To the Hospitel or Attent within 24 hours after deatt To the Funerel Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying P (Check only one)	hysician: To the t miner: On the bas and manne	sis of examina	owledge, deat ation and/or in	n occurred at the tir vestigation, in my o	ne, date and p pinion, death	place, and due to the occurred at the time,	cause(s) and date and plac	manner as s e, and due to	stated. the cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician 2009 June 10:42 Marie Wells Bette /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 9238 Geneveive Drive White Plains <u>Charles</u> Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2**X**□ F Feb. 1933 Washington, D.C 226-36-2736 76 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examilian must be notified at agine. 1 □Yes X□No Director Maryland Charles White Plains 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9238 Geneveive Drive 20695 USA Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. 3 X Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th. Own Home <u>Home Maker</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Constantine Zuras Philomena Dobricky 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William Wells, Jr./ Son 604 West Jasper Ct., Sterling, Virginia, 20164 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) St. Mary's Bryantown |June 8, 2009 Bryantow<u>n, MD.</u> 22. Name and Address of Facility Huntt Funeral Home 21. Signature of Funeral Service L 23a. Part 1. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line. 3035 Old Washington Rd. Waldorf, MD. 20601 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition 185 PULL VE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-transi Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. cate has been signed by the page 2 should be detached 9 Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed2 1 □ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2☑No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 ☐ Pending investigation 1 □Yes 2 □No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of seri D4250 009

Registrar
DHMH 17 Rev 1/2001

State

12070

31. Date filed (Month, Day, Year)

MARDORF

20602

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUN 0 8 2009

DLD LINE CENTER #

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 0.0 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 5:15 2009 7 Wright 12050 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner (Sultimore Bultmore Medical Center niversity 0+ If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year) **Funeral** Months Days Hours 1 M 25 220-16-7870 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercises creat be notified at once. 1 ☐Yes 2 ☐ No Maryland Anne Arundel Director Annapolis 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 21403 940 President St. USA Apt B3 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2 ∐No Baltimore, Maryland 21215-0036 Specify: Specify: Black δ 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Custodian State of Maryland 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Hamilton Edgar Washington ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21403 19a. Informant's Name/Relationship (Type. Print) Larry E. Wright (Son) 940 President St. Apt B3 Annapolis, Md. Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 6-1-09 Baltimore, Md. Wanname Protestes of Eacil Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. EE N. 1100483 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Se105:5 /Medical Due to (or as a consequence of): Examiner KRONUTUNY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Examiner the burial-tran Due to (or as a consequence of): physician attending ph for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☒No 5 Other (specify) been signed by the should be detached 9 Linknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas 2 s autopsy performed? his certificate ha I director, page 2 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work?

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, After within 24 hours after death.

To the Funeral Director:

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1 Natural
2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) and manner stated.

29b. Signature and title of certifier

29c. License number

maylak

Pucm Fellow

29d. Date signed (Month, Day, Year)

medical certa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

bert

31. Date filed (Month, Day, Year)

Régistrar's Signature

State Registrar

09-04800								
Lynne Adams								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Time of Death 1 Decedent's Name (First, Middle Last) Physician/ lams 1020 hrs Medical Examiner June 17, 2009 4a. Facility Name (if not institution, give street and number) c. County of Death 4b. City, Town, or Location of Death 1801 Division Street **Baltimore** 5. Social Security Number 5,656 9. Birthplace (State of Foreign If Linder 1 Year If Linder 24Hrs. 8. Date of Birth (MM/DD/YYY 6. Sex 7. Age (In yrs, last birthday) **Funeral** Months Davs Mir Director 53 Country M 2 X Yrs 3 60 G Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b County 1 14Yes 2 23a or 28a-f show notified at once. 1 more Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 21218 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. tant: If item 27 is marked other than "natural", or items or other traumatic event, the Medical Examiner must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 2 X No Yes Yes 2 No specify: 4 X Divorced If Yes. Give Year Specify: Widowed ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) filed within 72 Iltimore, MD 21215-0036 nit. Pages 1 and 2 should be filed within 7 artment of Health and Mental Hygiene. tation 18.Mother's Name (First, Middle, 17. Father's Name (First, Middle, Last) Be Hamm nce 19a. Infor (Street and Number or Rural Route Number, City or Town, State, Zip Code) /Relationship (Type, Print) 19b. Mailing Address 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name crematory or other place) Burial 2 Cremation 3 Removal from State mportant: Other Specify Donation 5 22 Name and Address of Fact nature of Funeral Service License Part I. Enter the disease, or complications tha Approximate Interval caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or **Physician** Between Onset and failure. List only one cause on each line. /Medical Death Narcotic intoxication (Morphine) Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - transit Physician/Medical 5,perFh G892 6/24/09 23a,27,28a-f,perME, 8 XUNPENDED X AMENDED g893 7/6/09 TT Box 68760, 23d. Date of deliver 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Month Day Year Live birth Fetal death 3 Ectopic pregnancy past 12 months' Pregnant at time of death Other (Specify) Yes 2 No 9 ✔ Unknown a Unknown 23e. Did tobacco use contribute to the cause of death? Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 No 3 Probably 4 ✔ Unknown Records, P. Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 2 No ✓ Yes 2 1 🗸 Yes fo the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 Other: ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✓ Other: Scene Inpatient 2 1 ✓ Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: within 24 hours after uses...

To the Funeral Director: A unk Yes 2 X No Pending Fd 6/17/09 Fd 1000 h**t**s 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City BAITIMORE, MD DIVISION St BAITIMORE, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 X Could not be Suicide other determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 18, 2009 O.C.M.E. use of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) Registrar's Signatu

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 🦾 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5-3014 M **Physician** 12000 Mn Helen Ajifowobaje /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 5 TSNV Washington Medical Anne If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, **Funeral** Year) Days Months 51 01-26-1958 Nigeria 116-78-1558 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h. County 10a State 28a-f show iner must be notified at 11☑Yes 2 No Director MD N/A Baltimore City 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 0 items 23a 4109 Pascal Ave 21226 Nigeria Funeral death permit. Pages 1 and 2 should be filed within 72 hours after deat. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" A any injury or other traumatic event. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ∐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: ð 3 Widowed 4 Divorced African Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Health & Rehabilitation Licensed Practical Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Philomina Nwoko Laurence Ofuoma ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Tolu Ajifowobaje / Daughter 4109 Pascal Ave. Curtis Bay, Maryland 21226 20b. Place of Disposition (Name of cemetery, crematory or other place)

Epiphany
Episcopal Cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06-26-2009 Odenton, Maryland 21. Si nature of Funeral & rvi 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, 1411 Annapolis Road Odenton, Maryland 21113 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and ad ress of person who com leted cause of death (Item 23a) (Type, Rrint)

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imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Itant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.		20a Method of D	isposition		. 201	b. Place of	Disposition (Na	ame of ce	emetery,	D	ate 2	Oc. Location - O	ty or Town, Sta	le l
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isi Attre er de recte	by the	2 Accide		not be 28e	. Place of Injury			ctory, offic	ce building,	etc.	or Town, S	State) h Avenue , Bal	timore MD	
Division tal or Attendi	led ii	1 Natura 2 Accide 3 Suicide 4 Homic	deterr	nined (Sp	ecify) Townh	ouse / F	Rowhouse							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physicis.	£ (29a, Certifier		ysician: To th	he best of my kno	owledge, c	eath occurred a	at the time	e, date and	place, and	due to the caus	se(s) and manne	r as stated. due to the caus	e(s)
the H iin 24 he F	plete	(Check cnly one) 2	Medical Exam	niner:On the I	basis of examina	tion and/o	r investigation, i	III IIIy Opii	mon, acam	0000	it the time, date			Voor!
To t with To t	Соп	29b Signature	and title of certifie	and ma	nner stated				cense numb			29d. Date sign	ied (Month, Da	ıy, rear)
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			address of person		ed cause of death Ssistant Med	ical Eve	miner 11	1 Penr	Street.	Baltimor	e, MD 2120)1		
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DHMH 17 Rev 1/2001 OCME 2006

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Registrar 2009

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Items 23a, Pt1, 11, 25 per me, 1892, 06 19709 and Mental Hygiene Certificate of Death Red. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Baumgartnes 28 pM 20ston /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Rehabi 7. Age (In yrs. last b) Birthplace (State or Foreign Country) If Under 24 Hrs. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1/25/1958 51 MARYLAND Director 217-64-2926 Usual Residence of Deced 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location show Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must burnet that 1 ☐ Yes 2 ☐ No Director PARKVILLE BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21234 APT. B 8707 LOCH BEND DR. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1X Yes 2 No If Yes, Give Year or Dates: 72 hours after 1X Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ∐Yes 2 ∑No Specify: þ 3 Widowed 4 Divorced WHITE Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LABORER RESTAURANT 12TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DOROTHY BEALL CALVIN RICHARD BAUMGARTNER ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BALTIMORE, 21218 209 CHANCERY RD. MDCALVINA ANN BAUMGARTNER/SISTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State IMMANUEL LUTHERAN CH. 6/11/2009 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service License MOC21 TOWSON, MD 8521 LOCH RAVEN BLVD. 23a: Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) UNKADET **Physician** motory /Medical (or as a consequence of): Due V Examiner Ouadriplegia Sequentially list conditions, if any, leading to infinishing cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Neuromuscular Disease of Unknown Origin To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760, ROVED BY Physician/Medical CERTIFICA IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 5 Other (specify) 1 □Yes 2 □ No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 3 Probably 4 V Unknown 2 🗌 No 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 No 2 No 1 □Yes 1 □ Yes Division of Vital 25. Was case referred to medical examiner?

1X Yes 2 + Ho 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Boulevard, Baltimire, Margland 21218 3900 006 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

arnes Stellars		State of Maryland / Department of He. -For State Certificate of Decay Segistrar		ygiene Reg.	No. 20	09 985
Physicia ledical Examir	n/	1. Decedent's Name (First, Middle,Last) Sellers Junior Barnes	3	Date of Death Month D	ay Year	3. Time of Death 1005 hrs
Colour Examin		Scillers Barnes 4a. Facility Name (if not institution, give street and number) 4b. Cit	ty, Town, or Location of Death	June 14, 200	4c. County of Deat	
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Funeral Director			Under 1 Year If Under 24Hrs onths Days Hours Min.	-	C	rthplace (State or Foreign ountry) N C
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re Maryland or 28a-f show <u>fied at once.</u>	Director	10e. Street and Number 10f.	Zip Code	10g	. Citizen of What Co	untry?
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, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	Funeral	1 X Never Married 2 Married Armed Forces? If Yes, sp	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 2 X No specify:		White, etc.	rican Indian, Black, African
hours afte natural", Examiner	ē	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usi	work done	Specify: Am 6b. Kind of Business		
72 hou	eted	Elementary/Secondary (0-12) College (1-4 or 5+) during most of	working life. DO NOT use reti			
5-0036 ded within 72 Hygiene. I other than '	ompleted	10th Grade NA Labore			Construc	tion Co.
215-0 be filed v ntal Hygi rked oth	Be Co	17. Father's Name (First, Middle, Last) Arsell Barnes	18.Mother's Name	(First, Middle, Ma	Rogers	
ID 21215-003 should be filed withing and Mental Hygiene. 7 is marked other the natic event, the Med	To B	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addr	ress (Street and Number or I	Rural Route Numb	er, City or Town, Sta	te, Zip Code)
Tore, MD 2 ages 1 and 2 shou nt of Health and N t: If item 27 is n other traumatic		Elouise Barnes-Mother 2117 Mt	Holly Str	eet Bal	ltimore	MD
Baltimore, Moemit. Pages 1 and 2 Department of Health Important: If item 2 mijury or other traun		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (crematory or other place)	ace)		20c. Location - City o	
트립트트		4 Donation 5 Other Specify: King Mem.				stown, MD
Balti permit. Departm Imports injury o		21. Signature of Funeral Service Licensee 22. Name (6.3.8)	N. Gilmor	lie Fur	neral Ho Baltimor	me P.A. e. MĎ
Physician	f	23a. Part I. Enter the disease, or commications that caused the death. Do not enter the mo failure. List only one cause on each line.				Approximate Interval Between Onset and
/Medical Examiner	ì	Immediate Cause (Final disease a. Narcotic (morphine) in	ntoxication			Death
~(9)		or condition resulting in death) Due to (or as a consequence of):				
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30x 68760, death certificate be exe e attending physician a lor use as the burial -	M/UE	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de	eath 3 Ectopic pregn		23d. Date of deliver	ery Day Year
Box 6876 death certificat the attending phy of for use as the	sician/M	1 Voc. 2 No. 0 University 4 Pregnant at time of death 5 Other ((Specify)		0:	
the oy th	Phy	Part II. Other significant conditions contributing to death but not resulting in the underl	lying cause given in Part I.	23e. Did tob	acco use contribute	to the cause of death?
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Division at or Attendir is after death. In Director: A led in by the fu	ertification:	3 Suicide XX Could not be 28e. Place of Injury - At home, farm, street, fac	ctory, office building, etc.	28f. Location (St	reet and Number or	Rural Route Number, City Holly St
Di spitat nours a neral I	Cert	4 Homicide determined (Specify) rowhouse		Baltimor	re, MD	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Medical	29a. Certifier (Check only ane) 1 Certifying Physician: To the best of my knowledge, death occurred a wind only ane) 2 Medical Examiner: On the basis of examination and/or investigation, in				
To To	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (/	Month, Day, Year)
		Alle Brassel Mr	O.C.M.E.		June 15, 2009	
OCME		30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn	n Street, Baltimore, MD	21201		
	ate					
Regist		A 2 2000 Common				
STORY IT HEV 1/2	J ()	ORIGINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2009 a M June 5:55 Donald H. Buschman, Sr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Manor Care Towson Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Mary land Days Hours 1**X** M 2□F 83 June 16, 216-20-0948 1926 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 TXNo Baltimore Towson Director Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21286 306 Linden Ave. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Maryland 21/215-0036 White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Government Contracts +4 Procurator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ertel Josephine John Buschman ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health at
Important: If Item 27 Is
any Injury or other trau 306 Linden Ave. Towson, Md. 21286 Mr. Donald Buschman, Jr./ Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 【▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-18-09 Towson, Md. Hilltop Service Co. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licens York Rd. Towson, Md. 21204 1050 tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Inter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or a a consequence of) uknon **Examiner** 5 squentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician; The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): Box 68760, the attending physician Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9□Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate 1 | Yes 25. Was case referred to medical 26. Place of Death Check onl one Be examiner? Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manne Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? uneral 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29h. Signature and title of certifier

State Registrar

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year

Amend 29a per DVR 8893 7/16/09 TT ensure All Copies Are Legible.

amend item 36aper Macyland? Department of Health and Mental Hygiene

1 - State Amend #1 per NP, G893 7/15/09 Etertificate of Death

Reg. No. 200 Se 1. Decedent's Name (First, Middle, Last) Mildred Priscilla Christopolus 2. Date of Death 3. Time of Death Day Month JUNE 2009 MILDRED PRICILLA CIRISTOPOLUS **Physician** PM 15, 6:41 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE CATONSVILLE MAYFIELD HOUSE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Month Day Year)
July 15,1931 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 1 F 215-28-3664 77 Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show d 2 should be filed within 72 hours after death with the Maryla th and Mantal Hyglene. 77 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, Item 5.16 Erwinger, and to notified. 1 □Yes 2 No Catonsville Director Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21228 32 Wade Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No Baltimore, Maryland 21215-0036 White Specify. Specify: ģ 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Home Housewife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Μ. Fisher Annie Μ. George Samuel ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is n any Injury or other traun once. 32 Wade Avenue, Catonsville, Maryland 21228 JoAnn Robinson (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State June 19, 2009 Brooklyn Park, Maryland Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Lic McCully-Polyniak Funeral Home P.A. 237 Fast Patapsco Avenue, Baltimore, Maryland 21225 part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause are ach line. Approximate
Interval Between
Onset and Death

MKMOWY Immediate Cause (Final disease or condition resulting in death) Physician /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burlal-transit attending physician and for use as the burlal-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) P.0. cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ੬ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 No certificate 1 ☐Yes 2 No Division of Vital Assisted Livin 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Residence 6 X Other (Specify) Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Deat 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 ☐ Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cand manner stated.

Nurse Practitioner Medical 29a. Certifier nion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature 0 Ste G. Linthicum MD 2090

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deat 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2009 1:58 June JOAN COLLINS 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Anne Arundel Glen Burnie Glen Burnie Health & rehab. 8. Date of Birth (Month, Day, Year) I an. 24,1934 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min. 1 □ M 2 1 F Kentucky 212-30-1758 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No Glen Burnie Maryland Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21060 43 Chester Circle 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritai Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) M.V.A. Clerk 10 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Stella Whitt Hasse1 Rutherford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 43 Chester Circle, Glen Burnie, Marylan 21060 (Daughter) Dianne C. Drud 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 I Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayyiew Crematory 06-20-09 Baltimore Maryland 21. Signature of Fuberal Service Lices 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A 21122 Art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mediate Cause (Final 10 MUNTH LUNG CHRUNUMY METASTATIC resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 3 🔲 Ectopic pregnancy Day Month Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

ral", or Items 23a or 28a-f show Exercites roust be notified at

"natural"

of Health and Mental Hygiene.
item 27 is marked other than "natu
other traumatic event, the Medical

permit. Pages 1
Department of H
Important: If ite
any injury or ot

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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physician ar attending p ed by the After eral Director: A n 24 hours after o e Funeral Direct

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examine Physician/Medical þ Completed Be Certification: To Medical

		1 ☐ Yes 2 ☐ No 3 ☐ Frobably 4 ☐ Unknown
		24a. Was an autopsy performed? 1 □ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No 2
25. Was case referred to medical	26. Place of De	eath (Check only one)
examiner? 1 ☐ Yes 2 D No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury 28b. Time of Injury 48c. Injury at Work?	28d. Describe how injury occurred
3 Suicide 6 Could not determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)
	hysician: To the best of my knowledge, death occurred at the time, date and plaminer: On the basis of examination and/or investigation, in my opinion, death occurred and representated.	

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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29d. Date signed (Month, Day, Year) 29c. License number

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State Registrar

29b. Signature and title of certifi

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31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 19 Day 200^{Year} **Physician** 2:00 A M Jüne James Edward Collins /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Center Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/11/1932 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1**√2**M 2□ F 77 236-52-4404 West Virginia Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Modeal Examinating to other traumatic event, the Modeal Examinating to other traumatic event, the Modeal Examinating to other traumatic event, the Modeal Examination or other traumatic event. 1 ☐ Yes 2XXIIo Director Maryland Baltimore Essex 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21221 U.S.A. 714 Franklin Avenue Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 0 5 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1952-1**XX**es 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify. Specify: White þ 1954 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Steel Mill Steel Worker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Collins Louise Sponaugle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 336 Ida Avenue, Baltimore, Maryland 21221 Linda Mae Gorrell (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Gardens of Faith 06/20/2009 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A 21. Signature of Funeral Service Licen 1407 Old Eastern Avenue, Essex, Maryland 21221 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat ause (Final disease condition resulting in death) **Physician** mcer year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed and burial-tran Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE: for use a 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by to be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? (es 2 No certificate 1 ☐ Yes 2 ☐ No 1 Tyes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Assisted Living 1∐ Yes 2⊠No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 Pending investigation nours after death.

neral Director: Af

filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one)

Box 68760 P.0. Division of Vital Records, Hospital or Attending 24 hours a Funeral I within 2 To the I

Maryland 21215-0036

Saltimore,

State Registrar

29b. Signature and title of certifier

29c. License питber

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

N. Cherles St. Balto. Md 21205 6701 V 2 2 2009 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 15 ^{Day} 2009 ^{Year} Frances Mae June **Physician** Chapman 6:40a M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Center for Hospice Towson Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Days Hours 1 □ M 2 🖳 F 79 214-26-1851 10 1929 MD Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examples and any injury or other traumatic event, I'm Medical Examples and 1 Ves 2 □ No MD Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1530 Northwick Road 21218 USA Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: Black <u>≨</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th 12 should be filed whand Mental Hygies is marked other the 4 yrs. <u>Teacher</u> Public Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Melvin C. Cheeks Lucy Thornton ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2300 Ellamont St. 21216 Mary Louise Lee - Sister Baltimore, MD Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) King Memorial Park 6/20/09 Woodlawn, Md 23a. Pa 11. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest disease or condition resulting in death)

Address of Facility

March Funeral Home West

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Complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest disease or condition resulting in death) 4300 Wabash Ave. Balto., MD Approximate Interval Between Onset and Death Physician nima montes /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 ☐ Other (specify) □Yes 2 No Division of Vital Records, P.O. certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Ischemic 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence Other (Specify) 2 No 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

N

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				For State Registrar		State of	Maryian		rtificate of				Reg. No.	2009	19861
				1. Decedent's Name	e (First, Middle,	Last)					2.	Date of Dea Month	ith Day	Year	3. Time of Death
		Physicia /Medic			Wi	lliam Jo	hn Cond	ell, .	Jr.			June	17,	2009	11:25PM ^M
		Examin		4a. Facility Name (/	f not institution,	give street and nur	nber)		4b. City, Town, o	or Location	of Death		4c.	County of Death	n
						n Hospit	al			Bethe	sda			Mont	gomery
		Funeral		5. Social Security N		5. Sex 1 🛣 M 2 🗆 F	7. Age (In yrs.	last birthday Yrs.	If Under 1 Year Months Days		Min. 8.	Date of Birth (Month, Day	h /, Year)		hplace (State or Foreign untry)
		Director		028-20-			82	115.			M	arch 2	9, 19	92/ Mas	sachusetts
		and w		Usual Residence of 10a. State	10b. County		10c. Cit	ty, Town or L	ocation						10d. Inside City Limits
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		with Sa or	Ö			etna Str	a a #			2081	/1			United	States
		ns 2%	Funeral	11. Marital Status	4311 GI	12. Was Dece	edent Ever in U	.S. 13	Was Decedent of If Yes, specify Cub			y Yes or No-		14. Race - Ame	rican Indian,
	(O	ifter o		1 ☐ Never Marri	ied 2□ Marrie	Armed Fo	2 No		1 ☐ Yes 2 X No			can, etc.)		Black, White	e, etc.
	ĕ	urs a al', o	þ	3 🔀 Widowed	4 Divorced	If Yes, Giv Year or D	ve ates: WWI:	I	TLIYES ZLALINO	s specii;	у.			Specify:	White
	Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "hatural", or items 23a or 28a-f show he Medical Expresses ust be retified at	Completed	(Spec	15. Decedent's	s Education grade completed)		(Giv	edent's Usual Occu e kind of work done	e during mo	st of working		16b. Ki	nd of Business/	Industry
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('n	The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use	ğ	Part II. Other signi	ricant condition	ns contributing to d	eath but not res	sutting in the	underlying cause g	giveriiirai	CI.	1 🗆 `		. /	robably 4 Unknown
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~	of \	Physician; r this certific ral director,	2	1 ☐ Yes 2 ☐ 27. Manner of D ==	,	28a. Date	·	ER/Outpati 28b. Time	ent 3 🗆 DOA	4 🗆		e 5 Resi		6 ☐Other (Spe	ecify)
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1/	Si	vttendi death. ctor: /	icat	2 ☐ Accident 3 ☐ Suicide	6 ☐ Could n	ot be	of Injury - At h	l nome, farm, s	street, factory, office		1	If. Location (Street a	nd Number or Fi	Rural Route Number,
	Division	or A after Direct	Certification: To	4 🗌 Homicide	determi	ned build	ing, etc. (Spec	ify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or To	wn, Stat	e)	
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Ž		e Hos 24 h e Fur letely	Medical	(Check only one)	/2☐ Medical E	Examiner: On the I	pasis of examin ner stated.	ation and/or	investigation, in my	y opinion, o	death occurre	d at the time,	, date ar	nd place, and du	e to the cause(s)
3		To the within 2 To the сотрые	Me	29b. Signature and	d title of certifier		1 44			ense numbe				ate signed (Mon	
4				▶ lefter	saralge	ma-	- M.	w .	D-	270	560		6/	18/09	T
				30. Name and	lress of e son v	who completed cau	se of death (Ite	m 23a) (Typ	e, Print)		***		1	200	
20-	11					, M.D. 1				110,	Rockvi	11e, N	Mary	land 20	852
V		Sta		31. Date filed (Mo	nth, Day, Year)	32.	Registrar's Sign	ature -							
Y		Regist	rar	11.11	N 2 9 201	no /2-14	a d.	bar	KAP						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, ocation of Death Examiner If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last Months Days 1 🗆 M Hours 243 38 5368 24,1933 N.Carolina Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☐ No Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2916 Carver Rd. 21225 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify \$ Specify: black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) seamtress Kosenburg Co 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Herman Taylor Margie McKinley မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Worrell (daughter) 2916 Carver Rd. Balto, Md. 21225 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition veteran 30 cem Owings Mills,Md. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest 4⁄ Donation 5 ☐ Other (Specify) me and Address of Facility Vin B. Scruggs Funeral Home 2 E. Preston St. Balto, Md. ignature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the des th. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Er, Ton, 65 disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Examine that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mon Month Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ≥ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referre examiner? Be medica 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 27. Manni of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation

Box 68760, The law requires that the death certificate be P.O. Division of Vital Records,

burial-trar physician the attending p the signed by the has le 2 s page 2 this certificate To the Hospital or Attending Physician: After thi funeral (nours after death.

neral Director: Af within 24 hours a To the Funeral I

Funeral

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72 hours after death with

filed within 7 I Hygiene.

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainment.

Physician

Medical

Examiner

Baltimore, Maryland 21215-0036

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Registr	ar

Medical

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

6 ☐ Could not be

determined

Dawas

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated

1Ary

Registrar's Sig

1 TYes

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9

Physician
/Medical
Examiner

Funeral

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Ever: In a first the rectilled at once. To Be Completed by Funeral Director

Physician /Medical

Baltimore, Maryland 21215-0036

Examiner Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

For State Registrar		State of r	viaryianu		artment of a rtificate of			лептап		g. No.	009	19	863
1. Decedent's Name (F	irst, Middle, La	ist)						2. Date o		Day	Year	3. Time o	f Death
Anthony Jo	seph Di	Stefano			,			June	7,	2009	1001	1:45	Рм
4a. Facility Name (If not	, 5		,		4b. City, Town,		of Death			4c. Count		1	
Elkton Car 5. Social Security Numb			ion Cen		Elktor		r 24 Hrs.	8. Date o	f Rirth	Cec		nplace (State	or Foreian
194-30-873	3	1120 M 2□ F	68	Yrs.	Months Days			Aug	Dav.	1940	Cor	intry) 1sy1van	
Usual Residence of Dec 10a. State 10l	b. County		10c. City,	Town or Lo	cation							10d. Inside C	ity Limits
MD	Cecil		E1k	ton								1 □Yes	2 X No
10e. Street and Number			LIK	COII	10f. Zip Code				10	g. Citizen of	What Cou	untry?	
23 Warburto	on Hill					21922				U	SA		
11. Marital Status 1 □ Never Married 3 □ Widowed 4 □		12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	s? ∑]No	1	Was Decedent of If Yes, specify Cul 1 □Yes 2 🛣 No			pecify Yes on Rican, etc.	r No-	Bla	ace - Amer ack, White ify: Whi		
15.	. Decedent's E	ducation			dent's Usual Occu				1	6b. Kind of I	Business/i	ndustry	
(Specify of Elementary/Secondary 12		College (1-40	or 5+)	`life.	kind of work done DO NOT use retire nanic	ed) ed)	st of work	ang		auton	notiv	e	
17. Father's Name (Firs	st, Middle, Las	t)				18. Mot	ner's Nam	e (First, Mi	ddle, Ma	aiden Surna	me)		
Dominic DiS	tefano					Ca	rme11	a Sut	aer	io			
19a. Informant's Name	/Relationship	(Type. Print)	- 1	19b. Mailir	ng Address (Stree	t and Num	ber or Rui	ral Route N	umber,	City or Tow	n, State, Z	lip Code)	
Denise DiSt	efano/	spouse		23 V	Varburto	n Hil	l E1k	ton,	Mar	yland	2192	2	
20a. Method of Disposit 1 ☐ Burial 2 ☐ Ci 4 ☑ Donation 5 ☐	remation 3 L	Removal from Sta	20b. Plac	ce of Dispo netery, crer	sition (Name of matory or other pla	ace)		Date	2	0c. Location	ı - City or ⅂	Fown, State	
21. Signature of Funera			ector	St	2. Name and Addr cate Anat altimore	omy 1	Board	655	West	t Balt	imor	e Stree	et
disease or condition resulting in death) Sequentially list condition any, reading to mime cause. Enter Underlyin Cause (Disease or injuthat initiated events resulting in death) Last	ng ry	b	as a consequer	nce of):	i Cell li				, , , , ,	CJUST	13/3		
IF FEMALE: 23b. Was decedent pre in the past 12 mor 1 □ Yes 2 ☒ No 9 □ Unknown	nths?		h 2 ☐ Fetal d nt at time of dea	eath 3[ith 5[Ectopic pregnar Other (specify)	осу			_	N	Pate of deli	ivery Day	Year
Part II. Other significar	nt conditions	contributing to deat	h but not resulti	ng in the u	nderlying cause g	iven in Par	i I.	23e.	Did toba	acco use co	ntribute to	the cause of	death?
<i>H</i>	TN								1 ☐ Yes	s 2 □ No	3 Pr	obably 4 🗆	Unknown
D	M								Was an autopsy perform 'es 2		prior to death?	topsy findings completion of 2 No	available cause of
25. Was case referred to examiner?	to medical	Hospital:						th (Check o					
1 Yes 2 No 27. Manner of Death		1	atient 2 EF	R/Outpatier 8b. Time o	IL 3 LI DOM	4/4	Nursing He			nce 6 🗆 C		cify)	
	☐ Pending investigation	(Month,	Day, Year)	Injury	We	ork? ⊡Yes 2.	KĺNo		N	,			
3 ☐ Suicide 6	Could not b	177			eet, factory, office			28f. Locati	on (Str	eet and Nun	nber or Ru	ıral Route Nu	mber,
4 ☐ Homicide	40101111100	building,	etc. (Specity)	N/.				City o	r Town,	N/A	ŀ		
		hysician: To the be miner: On the basi and manner	s of examination										(s)
29b. Signature and title	of certifier				29c. Licer	se numbe	,		29	d. Date sign	ned (Month	h, Day, Year)	
► A	11/2	completed cause of KHAN	MD)		D	006	210	90		06	111	1200	9
30. Name and address	of person who	completed cause	of death (Item 2	3a) (Type,	Print)	STO	6			410	F	V TO A	141)
31. Date filed (Month, D	DAV Year)	KHAA	istrar's Signatur	i W	, ITI 6 H	ンハハ	561	1501	TE	# 103	12	1010	~ D
Date fried (MOIRI), L	July, Ibail	SZ. Hey	3 Olyllatul	1	A C								

DHMH 17 Rev 1/2001

State

Registrar

JUN 2 2 2009

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09-04443	
Edna Dorsch	

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State of Maryland / Department of Health and Mental Hygiene

Dorsari		1-For State Control of Health and Mental Health State Certificate of Death Registrar	yglerie 20 (9 198
Physici cal Exami	an/	1. Decedent's Name (First, Middle,Last)		3. Time of Death 0325 hrs
Jai Exam	1101	Edna Dorsch 4a. Facility Name (if not institution, give street and number) Harbor Hospital 4b. City, Town, or Location of Death Baltimore	4c. County of Death	
Funeral Director		5. Social Security Number and 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr Months Days Hours Min	. lp 7 1007	nplace (State or Foreigntry) unk
w any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 X Yes 2 No
ith the Maryland 23a or 28a-f show notified at once.	Director	MD Baltimore 10e. Street and Number 10f. Zip Code	10g. Citizen of What Coun	
vith the N s 23a or e notified		4116 Hague Avenue #1 21225 11. Mantal Status 12. Was Decedent Ever In U.S. 13. Was Decedent of Hispanic Origin? (S	USA pecify Yes or No- 14. Race - Americ	an Indian, Black,
hours after death with the Maryland 'natural'', or items 23a or 28a-f sho Examiner must be notified at once	by Funeral	Armed Forces? unk. 1 Never Married 2 Married 1 Yes 2 X No 1 Yes 2 X No 1 Yes 2 X No 1 Yes 2 X No 1 Yes 2 X No 1 Yes 2 X No 1 Yes 2 X No 1 Yes 2 X No 1 Yes 2 X No 1 Yes 2 X No 1 Yes 2 X No	Specify: who	
uld be filed within 72 hours after Mental Hygiene. marked other than "natural", cevent, the Medical Examiner	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Unk 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use results to the manual of the manual occupation (Give kind of during most of working life. DO NOT use results to the manual occupation (Give kind of during most of working life. DO NOT use results to the manual occupation (Give kind of during most of working life. DO NOT use results to the manual occupation (Give kind of during most of working life. DO NOT use results to the manual occupation (Give kind of during most of working life. DO NOT use results to the manual occupation (Give kind of during most of working life. DO NOT use results to the manual occupation (Give kind of during most of working life. DO NOT use results to the manual occupation (Give kind of during most of working life. DO NOT use results to the manual occupation (Give kind of during most of working life. DO NOT use results to the manual occupation (Give kind of during most of working life. DO NOT use results to the manual occupation (Give kind of during most of working life. DO NOT use results to the manual occupation (Give kind of during most of working life. DO NOT use results to the manual occupation (Give kind of during most of working life.)	work done unk lifeb. Kind of Business/Ir lifed) Own Home	idustry unl
ould be filed within a Mental Hygiene. s marked other that ic event, the Medic		17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, Maiden Surname)	unl
	To Be	19a. Informant's Name/Relationship (Type, Print) Arthur Dorsch, Jr. Son 19b. Mailing Address (Street and Number or 12617 Eveland Rd. Ri	unknown) Bural Boute Number, City or Town, State, dgely, MD 21660	Zip Code)
		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or	
permit. Pages I a Department of He Important: If ite injury or other to		21. Signature of Funeral Source Licensee 22. Name and Address of Facility Go	4/2009 Baltimore, nce Funeral Service	MD 4001 Rito Street Hy
hysician	H	23a Part I. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac value. List only one cause on each line.	WI 21223	Approximate Interval Between Onset and
/Medical xaminer		Imme Cause (Final disease or condition resulting in death) a. Smoke Inhalation Due to (or as a consequence of):		Death
	ь	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):		
ed nsit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
ficate be executed g physician and the burial - transit	Medical	UNPENDED #5,9,11,12,16a-b,17,18,19a-b,	22, per Fh G892 6/2	25/09 TT
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)	23d. Date of delivery Month D	Day Year
t the deal by the al ached for	Phys	Yes 2 No 9 ✓ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?
law requires that has been signed b 2 2 should be detar	ed by		1 Yes 2 ✓ No 3 Prot	bably 4 Unknown
ta or Attending Physician: The law requires that t is after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detac	Completed		autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes	completion of cause of
ysician: The his certificate director, page	B	25. Was case referred to medical examiner? Hospital: Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursel 1 Nursel 1 Nursel 2 ER/Outpatient 3 DOA Other 4 Nursel 1	k only one) ing Home 5 Residence 6 ✔ Other	r: Scene
tending Physicath. tor: After this the funeral din	tion: To	1 Ves 2 No Impatient 2 Errodupatient 3 Don 4 No. 27. Manner of Death 1 Natural 5 Pending Jun 4, 2009 28b. Time of Injury at Work? 1 Natural 5 Pending Jun 4, 2009 0301 hrs 1 Yes 2 No.	28d. Describe how injury occurred Subject in house fire	-
To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	2 M Accident Investigation 3 Suicide 6 Could not be determined (Specify) Multi-Family Apt.	28f. Location (Street and Number or Ru or Town, State) 4116 Hague Avenue Apt. #1, Balti	
Hospi 24 hou Funer tely fil	Medical Co	29a. Certifier (Check only one) 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	nd due to the cause(s) and manner as stat	ed.
the ple		and manner stated. 29b. Signature and title of certifier 29c. License number	29d. Date signed (Mo	
To the Hos within 24 ha To the Fun completely	Me	O.C.M.E.	June 5, 2009	
To the within To the comple	Me			

09-04716

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Michael Dennis Ed		rds	Sta	te of	Marylaı	nd / De	epar	tment of	Healt	h and	Menta	al Hyg	iene		20	0.0	1000
	R	For State egistrar					Certi	ficate of	Deati	<u> </u>		12	Reg Date of Death	. No.	<u> </u>	3. Time of	Death
Physician/ Medical Examine		. Decedent's Name	~		N3C	NIS	>			PRI				Day 009	Year	2003 1	
	4	a. Facility Name (if			eet and nun	nber)				own, or Lo		Death			ounty of Deat	th	
		104 Summit	Hall Road							ersburg			8. Date of Birth		ntgomery	idhalaaa (Cta	10.05
Funeral		Social Security Nu		6. Sex	1	7. Age (In	yrs. las	t birthday)	_	s Days	If Under				Ecro	ian	1
Director	4	569-82-	6457	1 X M	2F	5	/	Yrs					02/09	1195	W C	ountry)	turnia
	_	Jsual Residence of	Decedent 0b. County			1100	City T	own or Local	ion							10d. Inside	City Limits
w any	- 1		•			100.				b	- 1					1 Yes	2 No
and land	5	NARYLAND		gov r	Ter 4			Gaitl	10f. Zip		19		T 10	a. Citizer	of What Co	untry?	
the Maryland a or 28a-f shelified at once	3			/	11 6	0-00	1			208	27	7	L L).S	_		1
death with the Maryland or items 23a or 28a-f show must be notified at once.		104 Sci	mmi	HC	2. Was Dece	edent Eve	rin IIS	I 13 W					cify Yes or No-		, .	erican Indian,	Black,
r death with or items 23 must be no	2	1 Never Marrie	d 2 M	•	Armed Fo	rces?		lf N	es, speci	fy Cuban,	Mexican,	Puerto Ri	ican, etc.)		White, etc.		
ter de		3 Widowed	4 Div	orced If Y	Yes 'es, Give Yeer	2 X	No	1	Yes 2	X No	specify:			Sp	pecify: (STIHC	
urs aft tural" amine	ร⊢	15. Decedent's Ed		l or	Dates:		ed)	16a. Decede	nt's Usual	Occupation	on (Give k	kind of wo	rk done	16b. Kin	d of Business	s/Industry	
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exau		Elementary/Secon	ndary (0-12)		College (1-	-4 or 5+)				rking life. I			u)				
5-0036 led within 7 Hygiene. I other than the Medica	1						i	N	7155	5101	JAR	24				MPLL	YED
Hygic Hees	3 [17. Father's Name (- 0		-y-mpa-		0				First, Middle, M	naiden Si SN	ırname)	SULIA)5
121; d be fill ental I: arked went, I		BYRON 19a. Informant's Na		AM			DL	JARD Lago Mailir	a Address	(Street	⇒+}C	LY ther or Ru	ral Route Num				
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygier and the Maryland tante. If item 27 is marked other than "intural", or items 23a or 28a-f she or other transmite event, the Medical Examiner must be notified at once To Bo Completed by Firmoral Director	- 1					(Q ST							VILLE				
, MD and 2 sho ealth and em 27 is	Y	MARY LE I	osition) X	(010	121	20b. P	lace of Dispo	sition (Na	me of cem			Date	20c. Lo	cation - City	or Town, Stat	е
Baltimore, oemit. Pages 1 ar Department of Hec Important: If ite		1 Burial 2	Cremation		Removal fro	om State	cr	rematory or o	ther place	e)	SU	Noli	8/2009	20	TIM	WE MAI	RYLAND
timen ritant	ŀ	4 Donation 5 21. Signature of Fur	Other S	ecify:			1 7 10	22.	Name and	Address	of Facility	1			caai	unme	
Baltimore permit. Pages l Department of F Important: If injury or other		21. Signature of 1 di	tr. a.d.	< 1	14) Alex	in	54	SEP WO	HH.	BR	OUR	VE. BH	PITIL	TORE	MIDÓ	21217
Physician	+	23a. Part I. Enter th	e disease, or	complica	tions that ca	aused the	death.	Do not enter	the mode	of dying,	such as c	ardiac or	respiratory arr	est, shock	k, or heart	Approxi	mate interval n Onset and
'M-dical		failure. List onl Immediate Cause (I		on each	thero	sclei	coti	c car	liova	scu1	ar d:	iseas	se				Death
aminer		or condition resulting		Due	e to (or as a	conseque	ence of)):									
		Sequentially list cor		b	e to (or as a		onno of	۸۰						_			
	<u></u>	if any, leading to im cause. Enter Unde	lying Cause	C.	e to tor as a	conseque	ence or	,. 			_						
- is	Examine	(Disease or injury to events resulting in	death) Last	Due to (or as a consequence of):													
executed an and al - transit	gical -	TV		٦٥	AMENDED	23a	,PII	,27,p	erME,	, g89	3 //	6/09	TT			-	
S & TE	ĕ L	X UNPENDED							_					23d	Date of deliv	verv	
Box 68760, e death certificate be the attending physic ed for use as the bur		IF FEMALE: 23b. Was decedent			23c. If yes, 1 Live t		or pregr		etal death	3 [Ectopi	c pregnar	псу		Month	Day	Year
eath cert	Sicia	past 12 months			4 Pregr	nant at tim	e of dea	ath 5 (ther (Sp	ecify)				1			
Bo re dear the ar	اح	1 Yes 2 1			g Unkne			audina ia tha	undaduin	2 001100 5	ivon in P	ort I	23e Did to	ohacco u	se contribute	to the cause	of death?
s, P.O. Bc ires that the dee is signed by the a d be detached R	2	Part II. Other signi					at not re	sulting in the	underlyii	ig cause g	given iii r	art t.	1 Ye			Probably 4	
S, F quires an sign	Completed by	<u>Early</u>	acute	pnec	IIIO II LA								24a. Was	an	24b. Were	autopsy find	ings available
ord aw rec as bee	be be		. <u></u>		.								autor perfo	osy ormed?	prior death		
Rec The l	팃												1 ✔ Yes	2 No	1 🗸	Yes	2 No
tal l	8	25. Was case refer examiner?	red to medic		spital:		_ [of Death Other;	(Check c	Home 5	Posidor	nce 6 🗸 O	ther Scene	
Physical direction	္	1 Yes 27. Manner of Dear	2 No		28a. Date	Inpatient	2	ER/Outpatie 28b. Time o		DOA 28c. Iniu	ry at Wor		28d. Describe			THE P. COUNTY	
n O ding h. Afte	ᇹ	1 X Natural		ding	(Monti	h, Day,Year)	2001 111110	, ,		Yes 2	_					
Sio	ۊ	2 Accident	Inve	stigation	28e Plac	ce of Injury	y - At ho	ome, farm, st	eet, facto	ry, office b	ouilding, e	etc.	28f. Location (nd Number or	r Rural Route	Number, City
Division of Vital Records, halo or Attending Physician: The law requires after death. al Director: After this certificate has been significate has been significant by the funeral director, page 2 should be a proper or the funeral director, page 2 should be a proper or the funeral director, page 2 should be a proper or the funeral director, page 2 should be a proper or the funeral director, page 2 should be a proper or the funeral director or the funeral dir	Certification:	3 Suicide 4 Homicide		ld not be ermined	(Specify)		,						or Town,	State)			
Hospir Funer Funer ely fill		29a. Certifier (Check only	Certifying I	hysician	r: To the be	st of my k	nowled	ge, death occ	urred at the	he time, da	ate and p	lace, and	due to the cau	se(s) and	manner as	stated.	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici Completely filled in by the funeral director, page 2 should be detached for use as the burit	Medical	one) 2	Medical Ex	miner:C	on the basis	of examin	nation a	nd/or investig	ation, in r	my opinior	n, death o	ccurred a	t the time, date	and plac	ce, and due t	to the cause(s	
F 18 F 8	≧	29b. Signature and	title of certif					,	2	9c. Licens		r			_	(Month, Day,	Year)
				0	MI	1. 11	/			O.C.	M.E.			June	e 14, 2009 ————	9 	
2 1	-	30. Name and add								, _		145.5	004				
DE NY		Jack Titus I			hief Medi	F.				eet, Bal	ıtımore,	, IVIU 21	201				
Sta Registr		31. Date filed (Mon	ith, Day, Year	2. 200		egistrar's	Signati	D. 19	ark								

	1	For State Registrar				C	Certificate o	of Deat	h		Reg. No	.20	Uy	198	
	1.	. Decedent's Nam	ne (First, Middle, L	ast)						2. Date of De Month	ath Da	v '	Year	3. Time of De	
an al		MARY 1	LOUISE EH	IMAN								2009		10:12	
er	48	a. Facility Name	(If not institution, g	ive street and nu	ımber)		4b. City, Tow	n, or Location	on of Deatl	n	4c.	. County o	f Death		
		STELLA I	MARIS HOS	SPICE				MONIU				BALTI			
		. Social Security I		Sex 1 □ M 21√2 F		rs. last birthd Yrs	Months Da	ear If Und ays Hour	der 24 Hrs. rs Min.	8. Date of Bir (Month, Da	th a <i>y, Year)</i>		9. Birthp	place (State or Fi ntry)	
	-	220-10-	1504	-X	88	- 118	·.			7/22/	1920		PA		
	\vdash	0a. State	10b. County		10c.	City, Town or	r Location						1	0d. Inside City L	
jo		MD	DAT TIME	ארטפי		DAF	OVIVET T E					1 ☐ Yes 2[
Director	-	0e. Street and Nu	BALTIMO umber	ruc.		PARKVILLE 10f. Zip Code						tizen of WI	hat Cour	ntry?	
		101/ ED	TELIOOD DO	\AD											
Jera		1. Marital Status	GEWOOD RO	12. Was Dec		t Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe ff Yes, specify Cuban, Mexican, Puerto								A - American Indian,	
Funeral		1 ☐ Never Mar		2 X No		1 ☐ Yes 2 ☑ No Specify:						lack, White, etc.			
by		3√ Widowed	4 Divorced	If Yes, G Year or I	Dates:		I∐ Yes 2LX	TNO Spec	ту:			Specify:	1	WHITE	
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			Name/Relationship I. EHMAN			_	Mailing Address (Si								
11 8	1-			SON	100)7 WHITE isposition (Name of		RD.	LUTHER Date				1093 own, State	
	2	20a. Method of Di 1 ☐ Burial 2	Sposition 3	☐ Removal from		cemetery,	crematory or other	r place)		Date			,	,	
	L		15 ☐Other (Spec			METRO	CDDMAGOO	37 781/	~ //	/	$-\alpha M$	ATC 1/T	T T ED	1.00	
	2	21 Signature of F				PALITO	CREMATOR			22/2009	CAT	CIVIZIAT	وبثاماما	, MD	
	1	21. Signature of	Funeral Service Lic	ensee MOO			22. Name and A	ddress of Fa	acility T	HE JOHNS	SON I	FUNER	RAL I	, MD HOME, P.	
	2	23a. Part 1. Enter shock, or he Immediate Cause	the disease, or co eart failure. List on	mplications that y one cause on	217 caused the deach line.		22. Name and A 8521 LO	Address of Fa	ven B	HE JOHNS LVD. TO	SON I	FUNER	RAL I		
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State

JACKIE JONES, CRNP
31. Date filed (Month, Day, Year)
JUN 2 2 2009

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.
32. Registrar's Signature

09-04841 Veronica Eslie Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

eronica Eslie		State of Maryland / Department of Health and Mental Hygiene 1-For State Registrar Certificate of Death Registrar	eg. No. 200	9 1986
Physicia edical Exami			Day Year	3. Time of Death 0002 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 9702 Whitley Park Place Bethesda	4c. County of Death Montgomery	
Funeral Director		$213-85-4691$ $_{1}$ $_{M}$ $_{2}$ $_{XF}$ $_{Yrs.}$ $\stackrel{\text{Months}}{1}$ $\stackrel{\text{Days}}{2}$ $\stackrel{\text{Hours}}{1}$ $\stackrel{\text{Min.}}{0}$ $_{April}$	rth(MM/DD/YYYY) 9. Birth 29, 2009 Foreig Cou	
* any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
aryland Sa-f shov at once,	Director	Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 1	0g. Citizen of What Cour	1 Yes 2 X No
h the Mi 3s or 2	l Dire	9702 Whitley Park Place 20814	United Stat	
e, MD 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. Health and Mental Hygiene. The 7 is marked other than "natural", or items 23a or 28a-f show any r traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	White, etc.	can Indian, Black,
ours afte atural",	þ	3 Wildowed 4 Divorced in resident or Divorced in resid	Specify: W.T. 16b. Kind of Business/I	nite
)36 thin 72 h te. than "n edical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) O College (1-4 or 5+) O College (1-4 or 5+)	none	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after de Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or injury or other traumatic event, the Medical Examiner mi	Be Cor		· ·	_
D 212 should by and Ment is mark	To E	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Num		
re, MI 1 and 2: Health a Fitem 27		Olivia J. Easley / Mother 9702 Whitley Park Place, Bet 20a. Method of Disposition 20a. Method of Disposition 3 Removal from State crematory or other place) Olivia J. Easley / Mother 9702 Whitley Park Place, Bet 3 Place of Disposition (Name of cemetery, crematory or other place) June 22,	20c. Location - City or	
Baltimore, MD bernit. Pages 1 and 2 sho Department of Health and Important: If item 27 is njury or other traumati		4 Donation 5 Other Specify: Montgomery Crematorium, Inc. 2009	Bethesda,	
Ba permi Depa Impo		M01305 Robert A. Pumphrey Funeral Home, 7557 Wisconsin Avenue, Bethesda,	Maryland 2081	.4-3501
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arr failure. List only one cause on each line. Immediate Cause (Final disease a. Congenital heart disease	est, shock, or heart	Approximate Interval Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence of):		
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause C		
uted Id ransit	Exan	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.		
50, te be executed ysician and burial - transit	ledical	X unpended #1 as noted per ME G892 6/22/09 TT 23a,27,perME, g893 7/24/09 TT		
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - trans	ian/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	23d. Date of delivery Month	/ Day Year
Box e death the atte	Physician/N	1 Yes 2 No 9 Unknown Greath 5 Other (Specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did to	obacco use contribute to	the cause of death?
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Division of Vital Records, P.O. Ital are Actional Physician: The law requires that the start death. The faw requires that the start of the factor. After this certificate has been signed by led in by the funeral director, page 2 should be detach.	Completed	24a. Was autor perfo		topsy findings available completion of cause of
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of Vita Physicia er this ce	မ	1 Ves 2 No Inpatient 2 ER/Outpatient 3 DOA 14 Nursing Home 5 27 Mapper of Death 28a Date of Injury 28b Time of Injury 28c Injury at Work 2 28d Describe	Residence 6 Other	: Scene
ion of tending Ph	ation	1 X Natural 5 Pending (Month, Day, Year) 1 Yes 2 No		
Divis	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, S (Specify)	Street and Number or Ru State)	ral Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date		
To wit	Mec		29d. Date signed (Mor	nth, Day, Year)
		O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a)	June 19, 2009	
		Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201		
St Regis	tate trar			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month $\mathtt{p}^{\mathtt{M}}$ **Physician** 2009 2:45 June 16, WOODROW Ε. /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery 3118 Gracefield Road, Silver Spring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Feb • 18, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Year Hours Months Days **1**X M 2 □ F 1916 Feb. Pennsylvania 93 174-10-1950 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. We find Exp. in a final beneatified any once. 10a. State 10b. County 1 ☐ Yes 2√No Director Silver Spring Silver Spring MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20904 U.S.A. 3118 Gracefield Road, CC108 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 XXX Specify: If Yes, Give Year or Dates: Specify: ģ White 34 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Grade 12 College (1-4or 5+) Atlantic Oil Company Chauffeur 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Fosbinder Elmer Frey ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8604 Snowden Loop Laurel, Maryland daughter Sonia Redfield 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Northampton Mem Shrine 6/19/2009 Easton, PA 4 □ Donation 5 □ Other (Specify) 21. Signature of uneral Service Licensee 22 Name and Address of Facility ral Home, P.A. + M00770313 Talbott Avenue Laurel, Maryland 23a. Part 1. Enter the disease, or c shock, or heart failure. List of Approximate Interval Between nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure **Physician** /Medical Due to (or as a consequence of): Examiner Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.0. 9 | Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Š 1 ☐ Yes 2XXNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 **X**(**X**) 1 ☐ Yes 2 **X K**0 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 MResidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 XX tural 5 Pending 1 ☐ Yes death. neral Director: ρ investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide after hours within 24 hours a

10

State Registrar 29a. Certifier

(Check only one)

29b. Signature and time

30. Name and address

Andrew Kundrat,

cal

of person who completed cause of death (Item 23a) (Type, Print)

M.D.

1 X Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3110 Gracefield Road, Silver Spring, Maryland

D 0036716

29d. Date signed (Month, Day, Year)

June 18, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician June 5, 2009 7:45 AM M Marjorie L. Freitag /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2010 Copperwood Way Harford Fallston If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 □ M 2 🖸 F Yrs. Director 215-30-5974 75 May 18, 1934 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a, Slate 10b. County 10c. City, Town or Location r then "naturel", or iteme 23a or 28a-f ehow the Medical Example: out by notified at 1 ☐ Yes 2 ☑ No Director Harford Fallston 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21047 USA 2010 Copperwood Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white Completed by 3 ₩ Widowed 4 Divorced 16a. Decedeni's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry permit. Pages 1 and 2 should be filed within. Depertment of Health and Mental Hygiene, important: if I tem 27 ie marked other then "nany injury or other treumating." Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charles Alvin Krieg Palma Kathrine Bach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2010 Copperwood Way Fallston, Maryland 21047 Pam Winchester/niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 ☐Removal from State 4 ☑ Donation 5 ☑ Other (Specify) 21. Signature of Funeral Service Licensee ROA11 S Wade 22. Name and Address of Facility
State Anatomy Board 655 West Baltimore Street Director Baltimore, Maryland 21201 Approximate Interval Between Onset and Death 23a. Part1 Enter the disease or complications that caused the shock, or heart failure. List only one cause on each line. that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) CEREBRAL **Physician** VASCUL day /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and I-transit The law requires that the death certificate be executed Due to (or as a consequence of): physicien a s the burial-t Box 68760. Physician/Medicai as ettending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at lime of death 5 Other (specify) ed by the e o. 9 Unknown ۵ been signed be should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has ! autopsy performed? Yes 2 2 No page 5 certificate 1 Yes 2□ No 1□ Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 ☐ Nursing Home 5 👿 Residence 6 ☐ Other (Specify) 2 1 ☐ Yes 2 ☑ No 3□ DOA 2 ER/Outpatient After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; or Attending 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier June 11, 2009 235522 MOD 30. Name and address of pers who completed cause of death (Ilem 23a) (Type, Print) BEL AIR MARYLAND 21014 NORTH WIL

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2009 June 9, P M 9:50 Martha Fisher /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore City 2644 Marbourne Avenue If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🔀 F Maryland Nov. 6, 1941 Director 214-38-0113 67 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10b. County 10c. City, Town or Location 10a. State 28a-f show other traumatic event, the Michael Exeminer must be notified at 1 ∑Yes 2 No Director Baltimore City Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number items 23a or 21230 USA 2644 Marbourne Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2√ No 5-0036 ò 1 ☐ Yes 2 No Specify: black þ 3 Widowed 4 Divorced 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within College (1-4or 5+) Elementary/Secondary (0-12) cook nursing home is marked other 18. Mother's Name (First, Middle, Maiden Surname) aryland 17. Father's Name (First, Middle, Last) Be ၉ Edgar Young Carrie Mae Madison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1401 East Oliver Street #b07 Baltimore, MD 21213 James Fisher/spouse Baltimore, Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition of ō 1 ☐ Burial 2 ☐ Cremation 3 Removal from State permit. Page Department of Important: If any Injury or once. 4□Donation 5₺Other (\$pecify) in sta/te/ State Anatomy Board 655 West Baltimore Street
Raltimore, Maryland 21201 Konald S. Wade Baltimore, Máryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. The cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) the attending physician and hed for use as the burial-tra resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23h Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) 1 ☐ Yes 2 ☐ No should be detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? significan conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by MARTH F Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 1 ☐Yes 2 ☐No al or Attending Physician; Tr s after death. al Director: After this certificate 1 ☐ Yes 2 No medical 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home Yes 2 **4** No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) Certification: To filled in by the funeral 27. Man of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 / atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated

within 24 hours a To the Hospital

0

DHMH 17 Rev 1/2001

State

Registrar

29b. Signature and title of certifie

31. Date fl

parke

29d. Date sigpled (Month, Day, Year)

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Guy Martin Gardner June 19. 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie Baltimore Washington Medical Center Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 216-48-4965 1 🙀 M 2 🗆 F 60 31, Maryland Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, It. It. Alcal Examiner International Contents on the contents. MD Anne Arundel Pasadena Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21122 USA 13 Poplar Road Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 X Married Saltimore, Maryland 21215-0036 1 ∐Yes 2 🙀 No Specify: <u></u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Security Company Service Tech \cap 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Katherine Margaret DeBoeser Charles Milton Gardner ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 Poplar Road Pasadena, Maryland 21122 Elizabeth Gardner 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville V.A. Cemetery | June 25, 2009 | Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully Polyniak Funeral Home P.A. 21. Signature of Funeral Service Licensee ONACO B204 Mountain Road Pasadena, Maryland 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** liste disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to minimulate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Directo for as a consequence of attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) nis certificate has been signed by the a director, page 2 should be detached it 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ npatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 □ No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

3. Time of Death

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

2.**2**4No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

White

1 ☐ Yes 2 🕱 No

D

6:15

Division of Vital Records.

the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of

2 Accident

3 Suicide

29a, Certifier

Medical

4 Homicide

29b. Signature and title of certifier

W55

6 ☐ Could not be

determined

State Registrar

N 8) 31. Date filed (Month, Day, Year)-

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Tel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Amend #7&10b per Inf. G892 6/24/09 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 24a,25 per dr., g892.06/22/09dhb Reg. No. For State Registrar 1-3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day 77 Year Month GRIMES 11:38 AM **Physician** WILLIAM 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NORTHWEST RUDALLISTO WIN Baltimore +cospi TAC If Under 1 Year If Under 24 Hrs. 8. Date of Birth

House Min (Month, Day. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Yrs. Min. 1 M 2 □ F Months Days Hours 231 - 20 - 8087 Usual Residence of Decedent 82 10d. Inside City Limits 10a, State County Baltimore 10c. City, Town or Location 1 Nes 2 No Directo MUNICH 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 181 21136 Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ Mo Specify: 1ac þ 3 ☐ Widowed 4 ☐ Sivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10# Irans 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kandolph Trimes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) raughter 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) barrison HOIRST 21. Signature of Funeral Service Licensee 22. Name and Address of Facility und Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CHRONIC OBSTRUCTIVE PULMONARY DISEASE Due to (or as a consequence of) Sequentially list conditions, Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by 3) Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2**X** No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No မ N Impatient 2 ☐ ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

Funeral

Director

or 28a-f show

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'natural'

other

Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event ODCs.

Physician

/Medical

Examiner

signed by the attending physician and the detached for use as the burial-transit

this certificate

After thi funeral

death I Director: P

within 24 hours a To the Funeral

death

filed within 72 hours after

Baltimore, Maryland 21215-0036

the Medical Examiner must be notified at

State Registrar

31. Date filed (Month, Day, Year) JUN 2 2 2009

29b. Signature and title of certifier

NORTHWEST



-000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MITCEA TODOK

29c. License number

D54352

29d. Date signed (Month, Day, Year)

MAY

COURT ROAD RANDAUSTOWN MD 2/133

2009

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 3:30 p^M Mary L. Galarza-Auchu June 16, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 331 Old Line Avenue Anne Arundel Laurel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, **Funeral** Months Days 1□M 2∏F Hours Director 578-70-0050 57 17, 1951 Washington, DC May Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Director MD Anne Arundel Laurel 1 ☐ Yes 2XXXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 331 Old Line Avenue 20724 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2XXNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □ Yes 2 🗓 📉 Specify þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health & Pension Elementary/Secondary (0-12) Grade 12 College (1-4or 5+) Account Executive Benefit Admn. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George W. Romick Lena Mary Guntow ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David J. Auchu spouse 331 Old Line Avenue 20724 Laurel, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 Cremation 3 ☐ Removal from State West Arundel Crematory 06/20/09 Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ²Donaldson funeral Home, P.A. _M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pancreas Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760,

burial-tra Certification: To

Physician/Medical

δ

Completed

Be

Medical

(Check only

29a. Certifier

23b. Was decedent pregnant

1 ☐Yes 2 ☐ No

in the past 12 months?

Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed funeral director, page 2 should be det To the Hospital or Attenct within 24 hours after death To the Funeral Director: filled in by

art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	3e. Did tobacco use contribute to the cause of death?
	1 ☐ Yes 2 ☐ No 3 ☐ Probably 🏋 Unknown
	4a. Was an autopsy performed? □Yes 2 ☑No 1 □ Yes 2 ☑No 1 □ Yes 2 ☑No 1 □ Yes 2 ☑No 1 □ Yes 2 ☑No 2 □ Yes 2 □
5. Was case referred to medical examiner? 26. Place of Death (Chec	ck only one)
Hospital:	XXesidence 6 □Other (Specify)
MXNatural 5 ☐ Pending (Month, Day, Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No	escribe how injury occurred
3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Loc Cit.	ocation (Street and Number or Rural Route Number, ity or Town, State)

3 Ectopic pregnancy

5 Other (specify)

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

State Registrar

29b. Signature and title of certifier naid O villa

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year) JUne 17, 2009

23d. Date of delivery

Day

Year

Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7525 Greenway Center Drive, Martin Weltz, M.D. Greenbelt, Maryland 20770

1 🖾 🗴 ertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D23743

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 17^{Pay} **Physician** 2009 Daniel W. Garrett June 10:24 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 749 Tiffany Drive Montgomery Gaithersburg 5. Social Security Number Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye January 15, **Funeral** 7. Age (In vrs. last birthday) Year. 1**X** M 2□ F Days Hours Min 215-72-9266 1963 Maryland 46 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10h Counts 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show 1 ☐ Yes 2 X No Director Maryland | Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20878 749 Tiffany Drive United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 □Yes 2**X** No Specify. Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) INOVA Blood event, the Mo Elementary/Secondary (0-12) College (1-4or 5+) Donor Services Blood Donor Recruiter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Luther E. Garrett Paula Meininger ဥ other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6522 Waters Edge Way, Bradenton, Florida 34202 Luther E. Garrett / Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Important; If it any Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State June Montgomery Crematorium, Inc Bethesda, Maryland 2009 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. M01305

Robert A. Pumphrey Funeral Home/Roc 300 West Montgomery Avenue, Rockvil

23a. Part I. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Years Coronary Artery Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. En the control of Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Hypertension 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 X No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner?
1 ☒ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 18, 2009 Kinner 006019 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5454 Wisconsin Avenue, #925, Chevy Chase, Maryland 20815 Harris Kenner, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

EXPIRED 6/18/09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	10H		1 - State Registrar	of Maryland / Depa	artment of F rtificate of			ene 2 ()	09	19875
	Physici	an	1. Decedent's Name (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·			2. Date of Death	Day	Year	3. Time of Death
-	/Medic		Joseph 4a. Facility Name (If not institution, give street and	rieco	4h City Town o	r Location of Death	June 18,	4c. County	of Dooth	10:00 A M
	Examir	er	Renaissance Gardens at Ride		Silver S			Mont		rv
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day,			place (State or Foreign htry) York
	Director		110-03-1733 1 [™] 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	91 Yrs.	Months Days	Hours Will.	Nov. 7,	1917	New	York
	land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				1	0d. Inside City Limits
	Mary I-f sh	ţo	Maryland Montgomery	Silver S	oring					1 □ Yes 2X No
	or 28s	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of W	/hat Coun	ntry?
	23a c	ral	3160 Gracefield Road		20904	4		Unite	d St	ates
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Exanting must be reathed at	Funeral	Armed	ecedent Ever in U.S. 13.1 Forces?	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - Americ k, White,	can Indian, etc.
36	irs aft	by F	If Yes,	s 2 □ No Give WWII	1 □Yes 2 🕅 No	Specify:		Specify.	Wh	ite
Ö	2 hou	Completed by	15. Decedent's Education	16a. Dece	dent's Usual Occup	ation	. 1	 6b. Kind of Bu	siness/Ind	dustry
2	ithin 7 ne. nan "r	nple		(Give iife. i	DO NOT use retired	during most of work d)	ring	D	•	
2	led will have the the the the the the the the the th	S	12		Owner		45	Printi		ompany
/lanc	uld be fi Mental H rrked ot rtic ever	To Be	17. Father's Name (First, Middle, Last) Paolo Grieco				e (First, Middle, Ma Chiapperi		e)	
Mar	nd 2 sho alth and 27 is ma		19a. Informant's Name/Relationship (Type. Print) Paul Grieco/Son			and Number or Rui				2227
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exaction of the traumatic event, the Medical Exaction of the provided and once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)	om State 20b. Place of Dispo cemetery, cren Mt. Carme		- unc	$23, W\epsilon$	oc. Location - oc.	City or To g Br	anch.
<u>≡</u>	rmit. I spartm portal y injul		21. Signature of Funeral Service Licenses	22	. Name and Addre	ss of Facility				-
<u> </u>	8 2 E 8	. 19	William A. Timph						a-Che	vy Chase, Inc
	certificate be executed Medical Examiner Ise as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Entitle Underlying Cause (Disease or injury that initiated events	Meach line. End stage demento (or as a consequence of): Severe anemia to (or as a consequence of): Severe debility to (or as a consequence of):	ntia					Approximate Interval Between Onset and Death
s, P.O. Bo	e law requires that the death certificate has been signed by the attending phys je 2 should be detached for use as the	by Physician/Medical	in the past 12 months? 1	egnant at time of death 5 ☐ nknown	Ectopic pregnance Other (specify)	,	23e. Did toba	23d. Date Mor	nth	ery Day Year ne cause of death?
0.0	een s		History of stroke		<u> </u>		1 Tes	2 💢 No	3∏ Prob	oably 4 Unknown
ľ	: The law cate has b page 2 st	Completed					24a. Was an autopsy performe 1 🗆 Yes 2	D	Vere auto rior to cor eath? Yes	psy findings available mpletion of cause of 2 No
VItal	ician certifi rector	Be	25. Was case referred to medical examiner? Hospital:		1046		h (Check only one)			
0	Phys	۲. ایا	1 165 2 2 2 2 3 40	☐ Inpatient 2 ☐ ER/Outpatien te of Injury 28b. Time of		4 A Nursing Ho	ome 5 Residen			y)
VISION	nding th. : Afte e fune	tion	1 X Natural 5 ☐ Pending (M 2 ☐ Accident investigation	onth, Day, Year) Injury	Work	y at (? Yes 2 □No	28d. Describe flow	rinjury occurre	, u	
DIVIS	al or Atter after des I Director d in by th	Certification: To	3 Suicide 6 Could not be determined 28e. Pla	ice of Injury - At home, farm, stre Ilding, etc. (Specify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Numbe State)	er or Rura	il Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical C	(Check only 2 Medical Examiner: On the	the best of my knowledge, death be basis of examination and/or invanner stated.	occurred at the tin estigation, in my o	ne, date and place, pinion, death occur	and due to the car red at the time, dat	use(s) and ma te and place, a	nner as s and due to	tated. the cause(s)
Ì	Vithii To th	ž	29b. Signature and title of certifier	CRNP	29c. License		290	d. Date signed	(Month,	Day, Year)
			Chaple	2	, .	75363		6/18	312	2007
j				160 Gracefield 1	Road, Sil	ver Spri	ng, Maryl	and	20904	4
	Stat Registra		31. Date filed (Month, Day, Year) 32 JUN 2 2 2009	Registrar's Signature	1					

DHMH 17 Rev 1/2001

09-04733

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Luis Salinas-Garci	State of 1- For State Registrar	Maryland / Department <i>Certificate</i>		lygiene Reg. No.	2009 1987
Physician Medical Examine	Decedent's Name (First, Middle,Last)	Campia		2. Date of Death Month Day	3. Time of Death 1625 hrs
R J	Luis Gonzalo Salir 4a. Facility Name (if not institution, give stre	eet and number)	4b. City, Town, or Location of Deat	June 14, 2009	c. County of Death
~	11636 Pleasant Meadow Drive		Gaithersburg	N	Montgomery
Funeral Director	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr Months Days Hours Min	1	/DD/YYYY) 9. Birthplace (State or Foreign
5,115,0.0.	220-63-3623 1XM Usual Residence of Decedent	2 F 25	Yrs.	April 27,	, 1984 Country) Peru
/ any	10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits
land f show	Maryland Montgomery	Gaithers			1 Yes 2 X No
te Maryland or 28a-f show fied at once. Director	10e. Street and Number		10f. Zip Code		izen of What Country?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11636 Pleasant Mead		20878 Was Decedent of Hispanic Origin? (S	Per	14. Race - American Indian, Black,
or death of or item	1 X Never Married 2 Married		If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.
s after ral", c	3 Widowed 4 Divorced If Ye	s, Give Year	X Yes 2 No specify: Pe		Specify: White
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan Completed	15. Decedent's Education (Specify only his Elementary/Secondary (0-12)		dent's Usual Occupation (Give kind of g most of working life. DO NOT use ref		Kind of Business/Industry
036 ithin 7 sne. r than fedica		,	enior Associate	В	ank
filed w Hygie d othe			18.Mother's Nam	e (First, Middle, Maiden	,
2121 ould be fil d Mental Is s marked tic event,	Abel Salinas 19a. Informant's Name/Relationship (Type.	Print) 19b. Mai	Elena (Garcia Lana	
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than numatic event, the Medica To Be Comple	Elena Garcia/Mother				hersburg, MD 20878
rre, land s 1 and freal free life item	20a. Method of Disposition 1 Burial 2 X Cremation 3 R	20b. Place of Dis	position (Name of cemetery, other place)	ne 19,	Location - City or Town, State
Baltimore, octmit. Pages I ar Department of Hee Important: If ite Injury or other tr	4 Donation 5 Other Specify:	Montgomery	Crematorium, Inc. 2	:009 В	ethesda, Maryland
Balt permit Depart Impor	21. Signature of Funeral Service Licensee	M01548 3	Name and Address of Facility, Obert A. Pumphrey Fune	ral Home/Rocky	ville, Inc.
Physician	23a. Part I. Enter the disease, or complication	ons that caused the death. Do not ente	O West Montgomery Aver or the mode of dying, such as cardiac		ock, or heart Approximate Interval
/Medical kaminer	failure. List only one cause on each lir Immediate Cause (Final disease a. Mi	_{e.} xed drug (heroin)	and alcohol into	xication	Between Onset and Death
	or condition resulting in death) Due t	o (or as a consequence of):			
ner	Sequentially list conditions, if any, leading to immediate Due to cause. Enter Universitying Cause	o (or as a consequence of):			
ted Insit Examiner	(Disease or injury that initiated C.	o (or as a consequence of):			
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit completed by Physician/Medical Ex	d	02 07 00 6	200 7/00	100	
60, ate be execut hysician and e burial - tra		ENDED 23a,27,28a-f,	perME, g893 //23/	'09 TT	
OX 6876 eath certificate attending phy for use as the I	IF FEMALE: 23 23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregnancy Live birth 2	Fetal death 3 Ectopic pregna		d. Date of delivery Month Day Year
b. Box 687(the death certification by the attending pleched for use as the Physician/A	1 Yes 2 No 9 Unknown 9	Pregnant at time of death 5	Other (Specify)		ï
that the deat ed by the at detached for by Physical by	Part II. Other significant conditions cont	ributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ires that the signed by I be detach				1 Yes 2	No 3 Probably 4 ✔ Unknown
of Vital Records, Ing Physician: The law requires ther this certificate has been signered director, page 2 should be n: To Be Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Rec The la icate h			_	performed? 1 ✓ Yes 2 N	death? lo 1 ✔ Yes 2 No
Sector Sector	25. Was case referred to medical examiner?	al: a	26.Place of Death (Check		
of Ving Physical direction on: To	1 Yes 2 No	8a. Date of Injury (Month, Day,Year) 28b. Time of		ng Home 5 Reside	ence 6 🗹 Other; Scene
⊏ # ; `⊄ 0	' Natural 5 Pending		00 hrs ^{1 Yes 2X No}	unk	
Division of Virpinor of Virpinor Attending Physicours after death. Beral Director: After this filled in by the funeral director After this Certification: To I	3 Suicide 6 X Could not be	28e. Place of Injury - At home, farm, st	reet, factory, office building, etc.	28f. Location (Street a	nd Number or Rural Route Number, City 1636 Pleasant Meadow rsburg, MD
Div Hospital or 24 hours afte Funeral Dia tely filled in	20a Cartifica				
를 들 등 등	one) 2 Medical Examiner: On the	o the best of my knowledge, death oc ne basis of examination and/or investi	curred at the time, date and place, and gation, in my opinion, death occurred a	I due to the cause(s) an at the time, date and pla	id manner as stated. ace, and due to the cause(s)
Med con	29b. Signature and title of certifier	manner stated.	29c. License number	29d. I	Date signed (Month, Day, Year)
	mnon	1m	O.C.M.E.	June	e 15, 2009
-	30. Name and address of person who compl Russell Alexander MD. Assi		11 Penn Street, Baltimore, M	D 21201	
State				L Z 12U I	
Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Jumeth 20, 2009 Francis Charles Gregory 1:52 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Towson Baltimore Gilchrist If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Days 1 XM 2 ☐ F 217-12-9892 86 Director 9/11/1922 Mary Tand Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c, City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Its Modical Evantin we must be notified at 10d. Inside City Limits MD Baltimore Lutherville Director 1 ☐ Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8719 Valleyfield Road 21093 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 1XYes 2 □ No If Yes, Give Year or Dates: WW I I Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 9 1 ☐ Yes 2 🙀 No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mid Atlantic General Manager General Motors 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alphonse Gregory Anna Ritter ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Schfer / Daughter 5 Kincaid Court Baldwin, Maryland 21013 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/24/2009 Dulaney Valley Mem. Timonium, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Towson, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Lew disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if an, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): burial-Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2: 2 No 1 ☐ Yes 2 ☐ No 1 □ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 🗆 No filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier

Division of Vital Records, P.O. Box 68760, Hospital or Attending 24 hours after death Pruneral Director: the within 7

> State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

025205

29d. Date signed (Month, Day, Year)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (Figst, Middle, Last) tagnes Day Month 30 PM 3 Physician June 16 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Neme (If not institution, give street and number) Examiner nien YUSINA e/ more If Under 1 Year 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Funeral Days Hours Months 18 M 2□ F 239.40-8777 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show Department of Heelth and Mental Hygiens I remove steer useath with the Maryl Important: if item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at proce. 1 √Yes 2 No by Funeral Director more 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number WOY Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Merital Status Peges 1 end 2 should be filed within 72 hours efter Yes 2 Yes, Give 2 □ No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0020 Specify: Specify: 3/ac 3 ☐ Widowed 4 ☑ Divorced Year or Dates: Completed 15. Decedent's Education (Specify onfy highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry School Nursing Elementery/Secondary (0-12) College (1-4or 5+) Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Wal ther Harnes GROYA ter 19e. Informant's Name/Relationship (Type, Print) (Daughter) 19b. Mailing Address (Street and Number of Burel Route Number, City or Town, State, Zip Code) 5105 Kenilworth Balto. MD 21212 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 20/09 6 Jundalk, MD 4 ☐ Donetion 5 ☐ Other (Specify) Cemetery armel 22. Name and Address of Facility 21. Signal o Funeral Service Licensee Funeral Homes P.A. L. RUSS 2222 W. North 23a. Part1. Implies disease, or complications that cau and the death. Do not enter the mode of dying, such as cardial or respiratory arrest, shock, or hear failure. List only one cause on each line. Baits. MD 21216 **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical an Examiner Due to (or es e consequence of): To the Hospital or Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician end Leres15 Division of Vital Records, P.O. Box 68760, 50 by Physician/Medical Due to (or as e consequence of) 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Completed 1 ☐ Yes 2 ☐ No 1 UYes certificate 25. Was case referred to medical examiner? Medicai Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this within 24 hours after deeth.

To the Funeral Director: After this completely filled in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 28b. Time of 27. Menner of Deeth 5 Pending investigation 1 Natural 2 Accident 1 🗌 Yes 2 No 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only onel 29d. Date signed (Month, Dey, Yeer) 29c. License number 29b. Signature end title of certifier 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 1)

State Registrar

31. Date filed (Month, Day, Year)

Dark

AEGM

32. Redistrer's Signeture

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 2 State of 2 Jaryland Desgring of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death HATTON ELIZABETH **Physician** Month 0310 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Howard County General Hospital Columbia Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Days Hours Min 1 □ M 2 □ F 1, Maryland Director 220-42-3483 61 Dec. 1947 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director MD Howard Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Exercitive must be no once. 9808 Robinson Blvd. 20723 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11 Marital Status Black White etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 □ Yes XIX No Specify. þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Grade 12 Human Resources Weis Markets 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marshal Graves Viola Sipes ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert A. Hatton, Jr. / spouse 9808 Robinson Blvd. Laurel, Maryland 20723 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XX urial 2 ☐ Cremation 3 ☐ Removal from State 5/22/2009 Cedar Hill Cemetery Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Donaldson Funeral Home, P.A. / M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part 1. Enter the disease, of shock, or heart failure. Lis complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death RILSELESS ELECTRICAL ACTIVITY Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ULMORAPU EMBO WS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine WALLERY with Prolonged Immobilization burial-trar Due to (or as a consequence of): attending physician for use as the buria Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No signed by the a d be detached for 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown peen s page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy The performed certificate I Division of Vital 2 🖪 No 2 3 NO 1 🗆 Yes Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ZEINO After this c Certification: To 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No neral Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifie Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

GIORGIO GALETTO

UN 1 9 2000

31. Date filed (Month, Day, Year)

32. Registrar's Signature

with.

HONARIS CO. GENERAL HOSP.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 **Physician** June 18, Marie Frances Hoff 7:28 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8604 Chestnut Oak Road Parkville Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3/16/1957 5. Social Security Number 9. Birthplace (State or Foreign 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🛣 F 396-68-9821 Wisconsin 52 **Director** Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examirer must be rediffed at 1 ☐Yes 2 ☐vNo Director MD Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8604 Chestnut Oak Road 21234 USA Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: if item 27 is marked other than "natural", or items 23, may or other traumatic event, it substical Examination man. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🙀 No ò Specify: White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Registered Nurse Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Fenhouse Patricia Gee ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Walker / Sister 10376 Boca Raton Drive Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Serv. Corp. 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/22/2009 4 □ Donation 5 □ Other (Specify) Towson, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Towson, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that cau and the death. Do not enter the mode of dyin, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus are an ine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) INUTE **Physician** mo /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed . Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed 1 🗆 Yes 2 25. Was case referre to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Hesidence 6 □ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manuer of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Watural 5 ☐ Pending investigation Injury within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and/manner stated.

State Registrar (Check only

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)

32. Reg

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month. Dav. Year)

LER DR. # 308 TOWSON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? [] [] 9 1 - For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 12:43 A M 2009 HOSLEY MICHAEL JUNE 18 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) 1 X M 2 □ F Days Hours 49 Sept.29,1959 218 72 0367 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits X Yes 2 No Director MD n/a Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 1618 E. Chase St. 21213 Funeral USA . Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11, Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: ģ Specify: black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore City Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willie Hosley, Jr. Ella Bell Foster မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Griffin (sister) 1618 E. Chase St. Balto,Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State ☐ Donation 5 ☐ Other (Specify) June 26.2009 Balto,Md Oaklawn Cemetery nature of Funeral Service Licenses 22 Name and Address of Facility Calvin B. Scruggs Funeral Home 1412 F. Preston St. Balto, Md. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, 21212 pproximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final SEPSIS disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Examine Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown ၉ Certification:

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

attending physician and I for use as the burial-tran certificate has been sig lirector, page 2 should funeral director. n 24 hours after death.

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Funeral

Director

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Department of Health and Mental Hygie Important: If item 27 is marked other tan any injury or other traumatic event, the once.

Physician

/Medical

Examiner

the Maryland or 28a-f show notified at

Pages 1 and 2 should be filled within 72 hours after death with nent of Health and Mental Hygiene.

nt: If item 27 is marked other than "natural", or items 23a or

Baltimore, Maryland 21215-0036

				•				24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No		
25.	. Was case referred to medical		26. Place of Death (Check only one)								
	examiner?	No	Hospital: 1X Inpatient 2	ER/Outpatient	3 🗆 DC	Other: 4 \(\sum \) Nursing I	Home	5 Residence 6	Other (Specify)		
	Manner of Deat Natural Accident		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	м 2	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d.	3d. Describe how injury occurred			
	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29	a. Certifier (check only		ysician: To the best of my kno						and manner as stated.		

29c. License number

KES-000

29d. Date signed (Month, Day, Year)

JUNE, 18, 2009

600 North Wolfe St, Baltimore, MD, 21287

State

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DEELA RANGACHARIS THE JOHNS THOPKINS THESPITAL 31. Date filed (Month, Day, Year) JUN 2 2 2009

29b. Signature and title of certifier

32 Registrar's Signature

SMEDICAL DOCTOR

and manner stated

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

thel Hendersor		State of Ma 1-For State Registrar	aryland / Departme <i>Certifica</i>			d Menta		Reg. No.	2009	9 19882
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. A		Johns Hopkins Bayview Medical			Baltimore				NA	
Funeral Director		5. Social Security Number 6. Sex 1 3 - 28 - 8894 1 M 2	7. Age (In yrs. last birth	hday) Yrs.	If Under 1 Year Months Day		Min. 8. Date of B	irth(MM/DD/ 5 - 2 3	Foreig	thplace (State or in untry) S C
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Locatio	on					10d. Inside City Limits
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Aaryland 28a-f show 1 at once.	Director	10e. Street and Number			10f. Zip Code			-	of What Cour	ntry?
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Baltimore permit. Pages 1 Department of P Important: If		21. Signature of Funeral Service Licensee					ylie Fu			
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/Medical Examiner			mal injuries	with	compli	<u>cations</u>	3			Between Onset and Death
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		30. Name and address of person who complete Theodore M. King, Jr., MD. As	Qause of death (Item 23a) sistant Medical Exami	iner	111 Penn St	reet Raltin	nore, MD 2120	.1		
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Maryland	12 sh th and 7 is m traum		19a. Informant's Name/Relationship						er, City or Town, State,	ND 21202
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P.O. Box	ng Physician: The law requires that the death certificate be executed the third certificate has been signed by the attending physician and mineral director, page 2 should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical	Inst initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a contributing to death but the late of Injury (Month, Day, 1) and be a contribution by the late of Injury and Injury and Injury and Injury and Injury and Injury and Injury and Injury and Injury and Injury and Injury and Injury and Inj	consequence of) consequence of) f pregnancy Fetal death ime of death not resulting in the second of the second	atient 3 □ DOA Other of Large Months of Large	ven in Part I. 26. Place of Dea her: 4 □ Nursing H iry at rk? □Yes 2 □ No	24a. Was autoperforment of the Check only of the Check only of the Check only of the Check only of the Check only of the Check only of the Check only of the Check only of the Check on the	Month obacco use contribute Yes 2 No 3 an	Day Year to the cause of death? Probably 4 ronknown autopsy findings available o completion of cause of es 2 No Decify) Rural Route Number, as stated.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 45 AM VENIAMIN KOLCHINSKY 2009 JUNE /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Dina. Hospital of 2014 mar City N/A so itimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Months Days Hours KIEV UKRAINE 218-37-9660 05/27/1924 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ?7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, I's Medical Examinar munition indiffed at Director 1 Yes 2 □ No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6940 BROOKMILL DRIVE, APT. #1B 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: WHITE Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, Its once. ENGINEER AUTOMOTIVE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **ISRAEL** KOLCHINSKY ANNA APPLEBAUM ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6940 BROOKMILL DRIVE, APT.#1B, BALTIMORE, MD 21215 LIDA KOLCHINSKAYA / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW 06/19/2009 | REISTERSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. scott 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** or torated a day 2Pands /Medicai Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy detached for in the past 12 months? Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Be Completed by Coronary actesn 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Hype xin 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s autopsy performed? Ves 2 No Diabetes 1 ☐ Yes 2 DNo 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

State Registrar 29b. Signature and title of certified

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

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Division of Vital Records,

Veriario

24384

29c. License number

BZ8529 325

MOSP BALTIMORE

29d. Date signed (Month, Day, Year)

and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAM SHED

09-04860 Ronald Koontz Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

Ronald Koontz	1- For State Registrar	Department of Health and Mental Hy Certificate of Death	Reg. No. 2009 1988
Physician <i>l</i> Medical Examiner	Decedent's Name (First, Middle, Last) Ronald G. Koontz		2. Date of Death Month Day Year June 19, 2009 3. Time of Death 1528 hrs
-	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
ø	University Hospital	Baltimore	N/A
Funeral Director	5. Social Security Number 6. Sex 7. Age (I	h yrs. last birthday) 66 Yrs. If Under 1 Year If Under 24Hrs. Months Days Hours Min.	8. Date of Birth(MM/DD/YYYYY) 9. Birthplace (State or 1/16/1943 Foreign Country) PA
any	Usual Residence of Decedent 10a. State 10b. County 10	Dc. City, Town or Location	10d. Inside City Limits
È.	MD Baltimore	Glen Arm	1 Yes 2 XNo
the Maryland a or 28a-f show tified at once.	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
th the Maryland 23a or 28a-f sho notified at once al Director	10 Manor Springs Court	21057	USA
hours after death with the Maryland "natural", or items 23a or 28a-f she Examiner must he notified at once ied by Furneral Director	11. Marital Status 1 Never Married 2 X Married Armed Forces?	rer in U.S. 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	
, or its	I Never Married Z NiMarried —	No 1 Yes 2 X No specify:	Specify: White
urs aft tural" amine	Lor Dates:	eted) 16a Decedent's Usual Occupation (Give kind of w	ork done 16b. Kind of Business/Industry
57 3 - 1 To	Elementary/Secondary (0-12) College (1-4 or 5+)		
5-0036 ed within 72 tygiene. other than the Medical	5++	Supervisor	Baltimore Co. School (First. Middle, Maiden Surname)
	Harold Koontz	Marie B	
조 교육들이 ㅇ	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or R	ural Route Number, City or Town, State, Zip Code)
e, MD I and 2 sho Health and Fitem 27 is r traumati	James Menas / Friend 20a Method of Disposition	1115 Cowpens Ave To 20b. Place of Disposition (Name of cemetery,	wson, Maryland 21286 Date 120c. Location - City or Town, State
Baltimore, MD 2 bernit. Pages I and 2 shou Department of Health and N Important: If iten 27 is in njury or other traumatic	1 X Burial 2 Cremation 3 Removal from State	crematory or other place)	· · · ·
Baltimory permit. Pages 1 Department of I Important: If injury or other	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		25/2009 Hydes, Maryland
Depr.	Mulle	Ruck Towson Funera	wson, Maryland 21204 I Home, Inc. 1050 York Road
Physician	3a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.	e death. Do not enter the mode of dying, such as cardiac or	respiratory arrest, shock, or heart Approximate Interval Between Onset and
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)		Death
	or condition resulting in death) Due to (or as a consequentially list conditions, b.	pence or).	
iner	if any, leading to immediate Due to (or as a consequence cause. Enter Underlying Cause	uence of):	
ted Insit Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the control of	uence of):	
and and	d d		
'60, zate be ex physician he burial	IF FEMALE: 23c. If yes, outcome	of pregnancy	23d. Date of delivery
box 6876. the death certificate by the attending phy ched for use as the by Physician/M.	23b. Was decedent pregnant in the past 12 months? 1 Live birth 4 Pregnant at time	2 Fetal death 3 Ectopic pregna	ncy Month Day Year
Box e death the atte ed for u	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)	
P.O. es that the igned by the detached by I by Pl	Part II. Other significant conditions contributing to death b	ut not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✓ Unknown
ords, F w requires t s been sign should be a			24a. Was an 24b. Were autopsy findings available
Division of Vital Records, tal or Attending Physician: The law requires rs after death. In Director: After this certificate has been signed in by the funeral director, page 2 should be striffication: To Be Completed	,		autopsy prior to completion of cause of death?
I Re utificate or, pag	25. Was case referred to medical	26.Place of Death (Check of	1 ✓ Yes 2 No 1 ✓ Yes 2 No
f Vital I Physician: or this certifi ral director, To Be (examiner? 1 • Yes 2 No Hospital: 1 • Inpatient		g Home 5 Residence 6 Other:
n of Jing Ph After t funeral on: T	27. Manner of Death 28a. Date of Injury	28b. Time of Injury 28c. Injury at Work? 0617 hrs 1 Yes 2 No	28d. Describe how injury occurred Subject shot
Sior Attend death ector: by the	2 Accident Investigation	y - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City
Division o spital or Attending nours after death. Tilled in by the fune	Suicide Could not be		or Town, State) 10 Manor Springs Court, Glen Arm, MD
Hospi 24 hou Funer rely fil	20a Certifier	nowledge, death occurred at the time, date and place, and	
To the Hos within 24 h To the Fur completely	one) 2 Medical Examiner: On the basis of examinand manner stated.	nation and/or investigation, in my opinion, death occurred a	
. ₹	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) ME June 20, 2009
	30. Name and address of person who computed cause of dea	wy);	Julio 20, 2009
	Theodore M. King, Jr., MD. Assistant Med	dical Examiner 111 Penn Street, Baltimore	e, MD 21201
State	31. Date filed (Month, Day Year) 32. Registrar's	Signature Barks	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death Year 2 Date of Death Day Physician 500 1131 00S /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number Examiner Baltimore HOV501 Δ_1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Year) Days Min. Months 1 □ M 2 😿 F 89 Vrs JUNE 29,1919 VIRC Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show may Injury or other traumatic event, the Medical Everning must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No BALTIMORE Funeral Director MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No BLACK þ Specify: 3 XWidowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) BRICKFORD LUNCH WAITER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CLARENCE ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Date 20a Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee JR. FUNERAL HOME JOSEPH H. BROW 2140 N. FULTONAVE, BALTIMORE, MD 21217 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or sart failure. List only one cause on each line. Approximate Interval Between Onset and Death Lun ediate C ← e (Final 36V= **Physician** u -krown sulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): physician the burial Division of Vital Records, P.O. Box 68760 Physician/Medical attending p as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Month Day Year 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 □ Yes 2 WNo has certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 1. Natural 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide ח 24 hou. the Funeral Dire 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar Sash

Street

\$15190

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VELMOS

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 112W 1405 Omas JUN 02009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** JOHNS Battimor 8. Date of Birth If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 0272172600 Months Days Hours 12XM 2□ F 9 Maryland 215-57-6881 **Director** Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f show notified at 1 ☐ Yes 2 X No Director WV Hedgesville Berkelv 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a United States 25427 75 Conestoga Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married within 72 hours after White Baltimore, Maryland 21215-0036 1 □ Yes 2 No δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Not Self Supporting Dependent permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 Is marked other i any Injury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Kevin Lathwell Cynthia A. Bruning 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kevin Lathwell, Father 75 Conestoga Court, Hedgesville, WV 25427 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Leo Church Cem. 06/18/2009 Inwood, WV 4 ☐ Donation 5 ☐ Other (Specify) T.Harman 22. Name and Address of Facility Brown Funeral Home 21. Signature of Funeral Service Licensee 327 West King St., Martinsburg, WV 25402 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Vor Sus if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed burial-transit 14mphoD1954ic and Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical as the use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a Wasan page 2 certificate 1∐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 🕅 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD

DHMH 17 Rev 1/2001

Registrar

PATRICK 31. Date filed (Month, Day, Year)

JUN 2 2 **200**9

32. Registraris Signature

600 N. Wolfe St. Baltimore, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death JUNE Year **Physician** 3:10 PM Richard Leroy Lindsey 2009 /Medical 4b. City, Town, or Location of Death BALT TMORE 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner JAT I 920H AGNES If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral X**□ M 2□ F Months Days Hours Min 215-76-6662 49 Director 59 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or items 23a or 28a-f show the Medical Exeminar must be notified at Director Baltimore MD NA 1 ☐Xes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3213 Dorchester Road 21215 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status filed within 72 hours after 1∰Yes 2 ☐ No If Yes, Give ~ Year or Dates: o 1 Never Married 2 ☐ Married 1 ☐Yes 2 【No Specify. ≥ 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Modes. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 2yrs Various Jobs Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leroy Lindsey Eliza Fisher ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3213 Doschester Road, Baltimore, Md 21215 Eliza Lindsey-Mother 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arbutus, Md Arbutus Memorial 6/25/09 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final and preumo thomex **Physician** premmonia 3 Wee & disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner AIDS eurs. Sequentially list conditions Examiner Duri to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Yea 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes → No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate performe death? 1 ☐Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Pesidence} \) 6 \(\text{Other} \) (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manne Leath 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending investigation Iniury 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one)

The law requires that the death certificate be executed 68760 Box Ö ۵. Records, Vital Hospital or Attending Physician: of Division

AR

51

Baltimore, Maryland 21215-0036

24 hours a To the within 2

> State Registrar

29b. Signature and title of certifier

JUN 2 0 2009

AVE. MHD NAWRAS KORDS 900 CATON 31. Date filed (Month, Day, Year) Registrar's Signature

M.D.

KORN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

222 1

BALTIMORE

29d. Date signed (Month, Day, Year)

06/10/09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, amend #8 Per And BP Mayland/Olepartment of Health and Mental Hygierie Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Victor Reynolds Lougheed June 4, 2009 P^{M} 8:14 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Baltimore Towson Year) 1937 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Social Security Number 8. Date of Birth (Month, Day, Ye March 12, 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 ☐ F ^{Country)} New York 1934 Director 214-34-9518 72 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director Baltimore Towson 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21286 USA Funeral 1005 Katy Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No δ If Yes, Give Year or Dates: Specify. Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) engineer aerospace 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Victor Rudolph Lougheed မ Mary Elizabeth Hunter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Lougheed/spouse 1005 Katy Lane Towson, Maryland 21286 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4X Donation 5 Other (Specify) Signatury Funeral Service License Panald S/ Wade 22. Name and Address of Facility
State Anatomy Board 655 West Baltimore Street
Baltimore, Maryland 21201

Approximate Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate use (Final disease or contition resulting in dear) Physician SICH month /Medical ue to (or as a consequence of Examiner Sequentially list conditions, if any, loading to ininformate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consumer so of) Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a Was an has autopsy performed? certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 SOther (Specify) WS P(1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral C 29a. Certifier SertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 To the 29c. License number 58303 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Clearles ST 6701 31. Date filed (Month, Day, Year) 32, Registrar's Signature State Registrar

Amend #25 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2009 09 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Pandallstol 00 timore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. 1 eb. 24, Social Security Number 9. Birthplace (State or Foreign 6. Sex Age (In vrs. last birthday **Funeral** 1956 Months Maryland 1 □ M 2 1 F 213-72-6506 53 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland D. partment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, It. Medical Experiment to realthed any Injury or other traumatic event, It. Medical Experiment to realthed and 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 21 No **Funeral Director** MD Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21244 1931 Winder Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐Yes 2 ☑ No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupationunk
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unit 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Marie Callis James Joseph Lacy Jr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 112 Cross Key Road Baltimore, Maryland 21210 Mary Daily Lacy/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4⊠ Donation 5 ☐ Other (\$pecify) 21. Signature of Euneral Service Licensee Ronald S. Wade State Anatomy Board 655 West Baltimore Street Baltimore, Maryland 21201 D/rector 23a. Part 1. Enter the disease, or complication of hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirts, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Lause (Final disease or condition resulting in death) Physician 0 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if they leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner ending physician and use as the burial-transit the Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 D Ectopic pregnancy Month Day Year 1 Yes 2 No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Probably 1 🗌 Yes 2 🗌 No 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 1306 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director; After Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 053350 Northwest 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RRT, KO 6 6, m 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

wendo Landisc		State of Maryland / Department of Health For State Certificate of Death			2 0 I	09 1989	
Physicia	ın/	tegistrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death Month June 14, 20		3. Time of Death 1307 hrs	
edical Exami		Gwenola Ladisch 4a. Facility Name (if not institution, give street and number) 4b. City, To	own, or Location of Death	June 14, 20	4c. County of Dea		
		7450 Wisconsin Avenue Bethes			Montgomery		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under Months		_	(MM/DD/YYYY) 9. E Fore	eign	
Director	-	624-12-9610 1 M 2 X F 33 Yrs. Usual Residence of Decedent		August	18, 1975 Was	shington. D.C.	
any		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits	
fand fand fanow	ភ្ន		Chevy Chase	140	g. Citizen of What Co	1 X Yes 2 No	
ie Mary or 28a Fied at	Director	10e. Street and Number 10f. Zip (100			
215-0036 be filed within 72 hours after death with the Maryland hely given red other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at once.			20815 nt of Hispanic Origin? (Sp		14. Race - Am	States encan Indian, Black,	
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be C	17. Father's Name (First, Middle, Last) Stephan Ladisch	18.Mothers Name	, , , , , , , , , , , , , , , , , , , ,	te Bidault	-	
Z. 22 8 8 5	TO E	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address	(Street and Number or I	Rural Route Numb	per, City or Town, Sta	ate, Zip Code)	
imore, MD Z Pages 1 and 2 shou ment of Health and I mat: If item 27 is n or other traumatic		Stephen Ladisch/ Father 3222 Pic 20a. Method of Disposition 20b. Place of Disposition (Nam		Chevy C	Chase, Man	ryland 20815	
Baltimore, permit. Pages 1 an Department of He Important: If ite		1 Burial 2 X Cremation 3 Removal from State crematory or other place)		June			
Baltimore permit. Pages 1: Department of H. Important: If it		4 Donation 5 Other Specify: Crematorium 21. Signature, of Funeral Service Licensee 22. Name and A	Inc. 21 Address of Facility Ro	. 2009 ert <u>A</u> .	<u>Bethesda</u> Pumphrey	, Maryland Tuneral Home/ sconsinAvenue	
Dep Dep	3 8	MUU333 Betneso	ga, Maryiano	1 20014-	3301		
Physician Medical		23a. Part I. Effer the disease of complications that caused the death. Do not enter the mode of failure. List only one cause on each line.	f dying, such as cardiac o	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death	
Examiner		Immediate Cause (Final disease or condition resulting in death) A Multiple Blunt Force Injuries Due to (or as a consequence of):				Beati	
		Sequentially list conditions,					
	nine	if any, leading to immediate Due to (or as a consequence of): Couse. Enter Underlying Couse (Disease or injury that initiated				_6J	
ecuted and transit	Examiner	events resulting in death) Last Due to (or as a consequence of):					
execut ian and ial - tra	Medical	d. UNPENDED AMENDED					
ox 68760, eath certificate be ex attending physician for use as the burial	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliv	•	
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Vita	To B	1 V Yes 2 No			Residence 6 🗸 O	ther: Scene	
Division of Vital Records, P.O. Box 68760, to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after decora. The this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	ion:	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 2 1 Natural 5 Pending 128b. Time of Injury 1301 hrs	28c. Injury at Work? 1 Yes 2 ✓ No	Subject stru	now injury occurred ck by train		
risior r Attend ter death irector: n by the	ficat	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory,	, office building, etc.			Rural Route Number, City	
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the	Certification:	4 Homicide determined (Specify) Subway		or Town, S 7450 Wiscons	tate) in Avenue, Bether	sda, MD	
29.a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as death occurred at the time, date and place, and due to the cause(s) and manner as death occurred at the time, date and place, and due to the cause(s) and manner as death occurred at the time, date and place, and due to the cause(s) and manner as death occurred at the time, date and place, and due to the cause(s) and manner as death occurred at the time, date and place, and due to the cause(s) and manner as death occurred at the time, date and place, and due to the cause(s) and manner as death occurred at the time, date and place, and due to the cause(s) and manner as death occurred at the time, date and place, and due to the cause(s) and manner as death occurred at the time, date and place, and due to the cause(s) and manner as death occurred at the time, date and place, and due to the cause(s) and manner as death occurred at the time, date and place, and due to the cause(s) and manner as death occurred at the time, date and place, and due to the cause(s) and manner as death occurred at the time, date and place, and due to the cause(s) and death occurred at the time, date and place, and due to the cause(s) and death occurred at the time, date and place, and due to the cause(s) and death occurred at the time, date and place, and due to the cause(s) and death occurred at the time, date and place, and due to the cause(s) and death occurred at the time, date and place, and due to the cause(s) and death occurred at the time, date and place, and due to the cause(s) and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurre							
To t To t	Medical	and manner stated.	c. License number		29d. Date signed (
		WII (MAN)	O.C.M.E.		June 15, 2009	1	
		30, Name and address of person who completed cause of death (Item 23a)	Street, Baltimore, M	MD 21201			
<u> </u>	tate		Suleet, Datumore, IV	1201			
Regis		31. Date filed (Month, Day, Year) 32. Registrar's Signature 34. Agarest			OGM	F	

Physician
/Medical
Examiner

Funera Directo

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If item 27 fe marked other than "natural", or Items 23a or 28a-1 ehow any njury or other traumatic event, the Medical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	* Registrar			Oei ii	iicale	UIL	Jeani			Reg. No	o			
cian	Decedent's Name (First, Middle, Last)				_				2. Date of De Month	Da		Year	3. Time of D	
ical	LEAH			_EVI					JUNE	1			10:15	ΑM
iner	4a. Facility Name (If not institution, give s			4			Location	of Death		40	c. County		N1 (0	
	GOOD SAMARITAN NU 5. Social Security Number 6. Sex		EK In yrs. last birtl	nday)	BAL If Under 1	TIMO	If Under	24 Hrs.	8. Date of Bi	th.			N/A lace (State or	Foreign
1		M 200 F				Days	Hours	Min.		1950	3	Coun	DC	i draigir
	Usual Residence of Decedent								12/20/	150.				
	10a. State 10b. County	1	0c. City, Town	or Local	tion							1	0d. Inside City	Limits
ţ	MD N/A		BALT	MOR	Ε					1 X Yes 2 □ No			2∏No	
ire	10e. Street and Number		10f. Zip Code					10g. C	itizen of V	What Coun	itry?			
a D	3921 PINKEY ROAD		21215								USA			
ner	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. Wa	s Decede	ent of Hi	spanic Ori	igin? (Spe	ecify Yes or No Rican, etc.)	o-		e - Americ		
by Funeral Director	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 No If Yes, Give			Yes 2		Specify:		,		Specify		ITE	
d b	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Bu													
Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a.	Give kir.	nts Usuai nd of work NOT use	done o	<i>lurina</i> mos	t of work	ing	166. 1	Kina of Bi	usiness/Ind	dustry	
E G	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	TF	CHE		3 70100,	,			ΔP.	T EDI	JCATI	ΩN	
	17. Father's Name (First, Middle, Last)		1 - 1	·OIIL			18. Mothe	ər's Name	e (First, Middle				011	
To Be	JOSEPH		HIRS	SHFII	EL D		MOLI	ĪF				ROS	FN	
-	19a. Informant's Name/Relationship (Ty)	oe, Print)				(Street a			al Route Numb	er, City	or Town,			
	STANLEY LEVIN / H	USBAND	39	21 1	PINK	NEY	ROAD	. BAI	LTIMORE	. MI	212	215		
	20a. Method of Disposition		20b. Place of	Dispositi	on (Name	e of			Date	-		City or To	wn, State	
	1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		LIBERTY OF SHA	REI	KK TCL 7 TO N	EMET Vi	ΈRΥ¦(06/19	9/2009	RAI	ILAGN	STOW	N. MD	
	21. Signature of Funeral Service License		01 01111	22. N	lame and	Addres			L LEVIN					
	Scatt Mi	withen							ROAD -					380
	23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused th	e death. Do n	ot enter	the mode	of dyin	g, such as	cardiac	or respiratory a	ırrest,	11001000		Approximate Interval Betw	veen
•	Immediate Cause (Final disease or condition	ME	TAI	FAT	TIC		(0	بامد	CER				Onset and D	
	resulting in death)	Due to (or as a	consequence of	f):	110		$\sim \Gamma$	100	CE 11				0.10165	-5,
	Sequentially list conditions by CERVICIAL CANCER LARGE													
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):									1				
Examiner	Cause (Disease or injury that initiated events resulting in death) Last	•												
	resulting at death) Last	Due to (or as a d	consequence o	f):										
n/Medical														
₩e	IF FEMALE:	20 16												
	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 Live birth 2	Fetal death	3 □E	ctopic pre	gnancy						te of delive onth	•	ear
yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at tir 9☐ Unknown	ne or death	2110	ther (spe	спу)		-						
Completed by Physicia	Part II. Other significant conditions con	tributing to death but	not resulting in	the unde	erlying ca	use give	en in Part I	l.	23e. Did	tobacco	use cont	tribute to th	ne cause of de	ath?
d b									1 🗆	Yes :	2 🗹 No	3 Prob	ably 4 🔲 U	nknown
ete									24a. Wa	s an	24h	Were auto	nsy findings a	vailable
를									auto			prior to co	psy findings a mpletion of ca	use of
	25. Was case referred to medical						00 Di	n of David	1 Yes		lo	1 🗌 Yes	2□ No	
examiner?														
n; To	27. Manner of Death					Bc. Injury Work			28d. Describe				y /	
atio	1 ↑ Natural 5 Pending 2 Accident investigation	1 Natural 5 Pending (Month, Day Y					<br Yes 2 ☐	No						
E .	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	- At home, far (Specify)	m, street	t, factory,	office			28f. Location City or To			ber or Rura	al Route Numt	oer,	
Cer		Danding, oto.	opoony,						ony or re	wii, Old	,			
Medical Certification;	29a. Certifier 1 Cartifying Phys (Check only one) 2 Medical Examin	ician: To the best of ar: On the basis of each manner state	kamination and	death o	ccurred a	it the tim	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time	cause(date a	s) and ma nd place,	anner as s and due to	tated. the cause(s)	
₩.	29b. Signature and title of certifier	n 0	M N		29c.	License	number			29d. D	ate signe	ed (Month,	Day, Year)	
	I June c	lil			() 7	27	22	90		6	19	(99	
1	30. Name and address of person who co	mpleted cause of dea	th (Item 23a) (Type, Pri	int)		0	5 (4				•		
	5601 LOU	1 REVE	5 N	Br	-VD)	KA	ttl	MORE		1. P	21	93.	1

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)
JUN 2 2 2009

Baltimore, Maryland 21215-0036 p. rmit. Pages 1 and 2 D. partment of Health a Important: If item 27 is any injury or other tra Physician /Medical Examiner Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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or items 23a

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Hygiene.

d 2 should be filed w th and Mental Hygie 7 is marked other ti

event, the Medical Examinar must be notified at

traumatic

Funeral Director

Be Completed by

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death with the Maryland

filed within 72 hours atter

Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Be Completed Medical Certification: To within 24 hours after death

To the Funeral Director:

completely filled in by the f within 24 hours a

To the Funeral C

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31. Date filed (Month, Day, Year) State Registrar JUN 2 2 2009 DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. D

32. Registrar's Signature

resulting in death)	a.									
resulting in death)	Due to (or as a consequence of):									
	PNEUMONIA									
Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury hat initiated events	b. Due to (or as a conse juence of):									
esulting in death) Last	Due to (or as a consequence of):									
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		ctopic pregnancy ther (specify)	23d. Date of delivery Month Day Year							
Part II. Other significant conditions	contributing to death but not resulting in the unde	rlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown							
			24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No 1 □ Yes 2 No							
25. Was case referred to medical	26. Place of Death (Check only one)									
examiner? 1 ☐ Yes 2 X No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)									
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury 28b. Time of Injury Injury	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how injury occurred							
3 ☐ Suicide 6 ☐ Could not to determined	28f. Location (Street and Number or Rural Route Number, City or Town, State)									
	hysician: To the best of my knowledge, death o miner: On the basis of examination and/or inves and manner stated.		and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s)							
29b. Signature and title of certifier	. / A	29c. License number	29d, Date signed (Month, Day, Year)							
▶ A. J.	Helou, M.D	DØØ17695	June 18, 2009							

TOWSON, MARYLAND 21204

OSLER DRIVE

7601

backs

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Year **Physician** June 21 Sally Ann Miller 12:55A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Carroll Hospice Dove House Westminster Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8 – 2 7 – 1 9 4 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours Months 1 □ M 2√2 F Pennsylvania 207-32-5083 67 Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "moral Extendible Light In 1911 to 1919 once. 10a. State 10b. County 10c. City, Town or Location MD Carroll Sykesville 1 □Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 116 Schoolhouse Rd. 21784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Beautician Cosmetology 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Russell Beal Beatrice Hayman ၉ 19a. Informant's Name/Relationship (Type. Print)
Bradley Miller-son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Schoolhouse Rd. Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State St. John Cemetery 6-24-2009 Somerset, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Fun 22. Name and Address of Facility Fletcher Funeral Home PA 254 E. Main St. Westminster, MD 21157 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of The law requires that the death certificate be executed the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy jo in the past 12 months? Month Year 5 Other (specify) signed by the a d be detached for P.O. 1 ☐ Yes 2 X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed r this certificate had 2. No 1 ☐ Yes 2 ☐ No 1 □Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: $_{4\square \text{ Nursing Home}}$ 5 \square Residence 6 \square Other (Specify) $^{\text{Hospice}}$ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To nours after death.

neral Director; After this

y filled in by the funeral di 27. Man of Death Natural 2 ☐ Accident 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital of within 24 hours at To the Funeral C completely filled it 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 00061755 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TEMALA POOLE RD WESTMINSTER MAGAMA

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

Registrar's Signature

09-0481	6
Charles	Matthew

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2009 198	9	
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	1- For State Registrar			ate of Death		Reg.	No.	
Physician/ Medical Examine		First, Middle,Last)	Matthew	les Matthews	_	2. Date of Death Month Di June 17, 200		3. Time of Death 1600 hrs
and the second		k Avenue # 606	and number)	4b. City, Town, or Baltimore	Location of Death		4c. County of Death	
Funeral Director	5. Social Security Num	3 3 1 M 2	7. Age (In yrs, last bir	thday) If Under 1 Yea Months Days Yrs.		8. Date of Birth()	MM/DD/YYYY) 9. Bir Foreig Co	
Varyland 28a-f show aoy d at ooce	MAD	b. County	10c. City, Town	or Location).			10d. Inside City Limits 1 Yes 2 No
th the Maryland 23a or 28a-f sho ootified at ooc al Director	10e. Street and Number	Valbroo	k Ave Ant	10f. Zip Code 2	1216		Citizen of What Cou	A
hours after death with the Maryland 'oatural', or items 23a or 28a-f sh. Examicer must be notified at once ted by Funeral Director	- 3 Widowed	2 Married Ar	as Decedent Ever in U.S. med Forces? Yes 2 No slive Year	13. Was Decedent of His If Yes, specify Cubar	n, Mexican, Puerto I		14. Race - Amer. White, etc. Specify:	can Indian, 81ack,
2 1 To		ation (Specify only highe ary (0-12) Col	sst grade completed) 16a. lege (1-4 or 5+)	Decedent's Usual Occupate during most of working life.			Business/	Factory
be fill riced fent, and Be	Joh	n Matt	lews	=	18.Mother's Name	urta 1	loung	Tour
nd 2 short and 2 short and 2 short and 2 short and 27 is raumatic	20a. Method of Dispos	Relatio ship (Type, Principle)	20b. Place	b. Mailing Address (Street) of Disposition (Name of certory or other place)	nore C	irde 1	Bouton - City or	MD 21218
Baltimore, permit. Pages l.a Department of He Importact: If ite	4 Donation 5 21. Signal re of Funer	Other Specify:	Ceda	r Hill Cemet 22. Name and Address Jo Suph	ery 62 s of Facility	1	-len Bu	rnie, MD
Physician		one cause on each line.	that caused the death. Do n		such as cardiac or	respiratory arrest,	shock, or heart	Approximate Interval Between Onset and Death
xaminer	Immediate Cause (Fin or condition resulting i	n death) Due to (osclerotic Cardiovascu or as a consequence of):	llar Disease				Dedail
ed nsit Examiner	Sequentially list condition if any, leading to imme cause. Enter Underlyi (Disease or injury that	ediate Due to (ng Cause initiated C.	or as a consequence of):					
		d	#1 man ME	g892 6/25/0	9 TT			
		egnant in the	If yes, outcome of pregnancy	Fetal death 3 5 Other (Specify)	Ectopic pregnar	ncy	23d. Date of delivery	/ Day Year
P.O. Bc es that the dea igned by the a be detached fo		9_	Unknown uting to death but not resulting	g in the underlying cause g	given in Part I.		cco use contribute to	
- 8 E 8 -	<u> </u>	_				1 Yes 24a. Was an autopsy performe	24b. Were au	topsy findings available completion of cause of
tal Rection: The lectrificate bector, page		to medical		26.Place	of Death (Check o	1 Yes 2		es 2 No
F Vital Physician r this cert ral directo To Be	1 ✓ Yes 2	No Hospital:	i inpansit 2 2 200				sidence 6 🗸 Othe	r: Scene
on of \ coding Physical arth. or: After tl he funeral		Pending	. Date of Injury (Month, Day,Year)		ry at Work? Yes 2 No	28d. Describe how	vinjury occurred	
Division of Vital Records, To the Hospital or Atteoding Physician: The law requirt within 24 hours after death. To the Fuoeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should bedical Certification: To Be Completed	2 Accident 3 Suicide 6 4 Homicide	Could not be	e. Place of Injury - At home, f	arm, street, factory, office b	ouilding, etc.	28f. Location (Stre or Town, State		ral Route Number, City
To the Hos within 24 h To the Fuo completely		dical Examiner: On the	he best of my knowledge, de basis of examination and/or inner stated.					
	29b. Signature and title	e of certifier	/ r	29c. Licens O.C.I			9d. Date signed <i>(Mo</i> June 18, 2009	nth, Day, Year)
	30. Name and address Russell Alexar		ed cause of th (Item 23a) ant Medical Examiner	111 Penn Street,	Baltimore, MD	21201		
State Registra	31. Date filed (Month, I	Day, Year)	32. Registrar's Signature	hand			OCME	
DHMH 17 Rev 1/2001	00:	T R EUUS	OF	IGINAL				

09-04710 Dwight Madison Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 19895

		1- For State Registrar	Cer	tificate of D	eath		Re	g. No.		
Physicia	an/	1. Decedent's Name (First, Middle,La	ast)				Date of Deat Month		3. Time of Death	
ledical Exami	ner	D#19110	Jerome		Madis		June 13, 2	009	1205 nrs	
		4a. Facility Name (if not institution, g	ive street and number)	1		ocation of Deat	h	4c. County of	f Death	
		University Hospital	T= 4 (1)		altimore	Lett. (80)	- In Data of Bio	- / / / / / / / / / / / / / / / / / / /	Birthplace (State or Foreign	
Funeral Director			Sex 7. Age (In yrs. la		Under 1 Year fonths Days	If Under 24Hr Hours Mi	٦.	,	Country)	
Director			X M 2 F 48	Yrs.			07	L5 60	MD	
any		Usual Residence of Decedent 10a. State 10b. County	10c. City.	Town or Location					10d. Inside City Limits	
<u>*</u> .		MD NA		Baltimo	re				1 X Yes 2 No	
Maryland 28a-f show 1 at once.	흱	10e. Street and Number	1		f, Zip Code		1 1	og. Citizen of Wh		
e Ma or 28 fied a	Director								·	
with the Maryland ms 23a or 28a-f sho be notified at once.	je	1529 Penrose A	12, Was Decedent Ever in U.	S 13 Was De		1223	Specify Yes or No		• A • - American Indian, Black,	
eath v item ust bu	Funeral	1 X Never Married 2 Marrie	ed Armed Forces?			Mexican, Puert		White	, etc.	
fter d		3 Widowed 4 Divorce	1 Yes 2 No ed If Yes, Give Year	1 Yes	2 X No	specify:		Specify:	Black	
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	d by	15. Decedent's Education (Specify	only highest grade completed)	16a. Decedent's U	sual Occupation	on (Give kind of		16b. Kind of Bus	siness/Industry	
72 hc	eted	Elementary/Secondary (0-12)	College (1-4 or 5+)	· ·	J	DO NOT use re	tired)			
1036 tithin 72 ene. er than	Comple	12th grade	na	Disa	bled			Dis	abled	
215-0036 be filed within 7 mal Hygiene. rked other than ent, the Medica		17. Father's Name (First, Middle, Las	st)				•	Maiden Surname)		
2121 uld be fil Mental F marked	Be	Moses Madison				Annie				
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shumatic event, the Medical Examiner must be notified at once	은	19a. Informant's Name/Relationship			,				n, State, Zip Code)	
- P = E = -	- 1	Annie Madison- 20a. Method of Disposition		Place of Disposition			Balt1r Date	nore, M	Id 21223 City or Town, State	
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		1 X Burial 2 Cremation 3	Removal from State	crematory or other p	olace)					
ti. Par timen trant		4 Donation 5 Other Specia		rrison	Fores	t Vet	6/26/09	Owing	s Mills, Md	
Baltimo permit. Page Department of Important: injury or otd		21. Signature of Funeral Service Lice	V- Dage	Marc	and Address h F/H	West	D - 14 3		wa 21215	
Physician		23a. Part I. Enfer the disease, or con	inplications that caused the death	Do not enter the m	wabas lode of dying, s	such as cardiac	or respiratory arr	imore, est, shock, or hea	art Approximate Interval	
/Medical		failure. List only one cause on	each line. a. Head injuries	a with co	mulicat	ions			Between Onset and Death	
kaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of		шрттсас	.10115				
		Sequentially list conditions,	0							
	Examiner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of c.	f):						
±	хаи	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	f):						
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760, cate be ex physician the burial	/Medical	X UNPENDED	AMENDED 23a,27,28a-	-f,perME,	g898 1	2/10/09	TT			
, mo		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregr	nancy		Ectopic pregr		23d. Date of Month	delivery Day Year	
Box 68's death certiff the attending of for use as	sician	past 12 months?	4 Pregnant at time of de	oth	(Specify)					
BO) he deat the att	Phys	1 Yes 2 No 9 Unknow	a Olikilowii							
, P.O. ires that the signed by be detach	P P	Part II. Other significant conditions	s contributing to death but not re	esulting in the unde	rlying cause gi	ven in Part I.			bute to the cause of death? Probably 4 Unknown	
S, F							10.700000			
cord	흺	24a. Was an 24b. Were autopsy findings available 24b autopsy prior to completion of cause of								
Records, The law require ficate has been si	Completed						1 ✓ Yes		death? ✓ Yes 2 No	
tal Recian: The certificate ector, page	Be	25. Was case referred to medical examiner?				of Death (Checl	k only one)			
of Vital ng Physician: After this certi neral director	P	1 Y Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3			ing Home 5	Residence 6	Other:	
n of ding Pl After funera	崩	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day,Year)	28b. Time of Injury		y at Work? es 2 XNo	1 ~		^e head during	
SiOi Atten death death sector:	ä	2 Accident 5 Pending Investiga	ation 0/12/09	9:50 am			<u></u>	restrair	nt er or Rural Route Number, City	
Division al or Attendi ss after death. al Director: A	Certification:	3 Suicide 6 Could no			ictory, office bu	iliaing, etc.	or Town, S	State)	5.0	
Division of Vital Records, P.O. Box 68 Hospital or Attending Physician: The law requires that the death certif 24 hours after death. Funeral Director: After this certificate has been signed by the attending rely filled in by the funeral director, page 2 should be detached for use as										
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainter as stated.									
To with Con	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Date signed)							ed (Month, Day, Year)		
		MIL A.	nell MVD		O.C.N	1.E.		June 14, 20	009	
	ŀ	30. Name and address of person who	o completed cause of death (Item	23a)	I					
OGME	_	Melissa Brassell, MD	Assistant Medical Examir	ner 111 Pen	n Street, Ba	altimore, MI	21201			
		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	Jak)						
Regist	الثت	JUN Z Z 4003	Lewer B.	ALCO CALLAND						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Day **Physician** P^{M} 1:55 17 2009 June Beatrice Moonsammy /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard 9347 Kings Grant Road Laurel 8. Date of Birth (Month, Day, Year)
Aug. 22, 1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Days Hours 1 □ M 2 🛛 F Director 079-82-4100 77 1931 Guyana Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits if of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Wellen Evantine must be natified at 10b. County 1 ☐Yes 2 X No Director MD Howard Laurel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20723 South America 9347 Kings Grant Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No Specify ð Specify: Asian 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12th Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be should be Violet Charles John Steven Moonsammy ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health ar 9347 Kings Grant Road, Laurel, MD 20723 Bibi Rahaman/Daughter timore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. ō George Washington 6/19/2009 Adelphi, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee Laurel, MD 20707 M01103 313 Talbott Avenue, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Dementia disease or condition resulting in death) i /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Dissass of Injurithat initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 🖾 No Year Month 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, þ 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 □ Yes 2**X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 AResidence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X X atural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital
within 24 hours
To the Funeral I 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatu 31. Date filed (Month, Day, Year) State JUN 2 2 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** Year LEROY MCCULLERS 2009 101 June /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Koseo If Under 1 Year If Under 24 Hrs. Social Security Number & Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Age (In vrs. last birthday) Months Days Hours Min 1**X** M 2□ F Director 245-18-9966 90 APRIL 2,1919 Usual Residence of Decedent 10a, State show 10b County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Midical Examiner must be notified at Director MD BALTIMORE TURNER STATION 1X Yes 2 □ No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or Funeral 115 CHESTNUT STREET 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 □ No IfYes, Give Year or Dates: 1942-13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married aryland 21215-0036 o, 1 ☐ Yes 2 📆 No Specify þ Specify: 3 Widowed 4 Divorced 1942-45 BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health, and Mental Hygiene Important: If item 27 is marked other the any Injury or other traumatic event, 11 and 200ce. 12 STEEL WORKER BETHLEHEM STEEL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk. Be SERETHE MCCULLERS ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SYLVESTER MCCULLERS/SON 115 CHESTNUT ST. BALTIMORE, MARYLAND 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date IX Burial 2 ☐ Cremation 3 ☐ Removal from State CROWNSVILLE VET.CEM. 6-26-09 CROWNSVILLE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F. H., INC. 1701-31 LAURENS ST. BALTIMORE, MD 21217 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ISC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Physician: The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Jivision of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: for use 23c. If <u>ye</u>s, outcome of <u>pr</u>egnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) the 9 Unknown signed by 1 1 be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy 1 □ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural
2 Accident 5 ☐ Pending investigation (Month, Day, Year) 1 ☐ Yes 2 □ No after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide i 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only within 2 To the I 29b. Signature and title of certifier 29c. License number lin, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 -ranklin 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

State Registrar Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20a-c State of Maryland Beharment of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. C 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 0:24 William Medley JUL /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Bullywore City t Cospitul 8. Date of Birth (Month, Day, Oct 7, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security NumbelUnk | 6. Sex **Funeral** Days Hours 1X M 2□ F Maryland 82 Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be reaffied at once. 1 √ Yes 2 No Director MD Baltimore City Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21215 USA 3939 Penhurst Avenue Funeral Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: 2 3 ₩ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) steel industry pipe layer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Agnes Medley James Nelson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2903 Baker Street Baltimore, Maryland 21216 Kevin Medley/nephew 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition **XX**Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 3 ☐ Removal from State 4 ☐ Donation 3 ☐ Removal from State 1 ☐ State 1 ☐ State 2 ☐ S Baltimore, MD MT. CArmel Cemetery 6/19/09 22. Name and Address of Facility Rendon-Bailey Funeral Home P.A. State Anatomy Board 035 West Baltimore Street Ronald S. Wade, Director Baltimore, Maryland 21201 21224 2818 E. Balto ST 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) DXCLO Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) that the death certificate be executed Exami burial-tran and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 ☐ Other (specify) signed by the a d be detached for □Yes 2□No 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Nnknown icate has been sig 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 2 No 2 No 1 ☐ Yes 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27 Maprier of ath Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural Accident 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier l 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sihai Lutur 31. Date filed (Month, Day, Year) 32. Registrar's Sig JUN 2 2 2009 Registrar

Medly, Will

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year MANLY - CLARK 11:44 PM TUNE 2009 THDA 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMOIZE Baltimore JOHNS HOPKINS BATVIEW MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Numberunk 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Year) Months Days 1 □ M 2 💢 F unk 47 May 27, 1962 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 □ No Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 5702 Harford Road #2 21214 **IISA** 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status unk Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify: White Specify 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Hopkins Bayview Hospital 4940 Eastern Avenue Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 🕅 Other (Specify) in state 21. Signature of Romald's icensee State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ca (Final disease or condition resulting in death) TRAUMATIC BRAIN WEEKS Due to (or as a consequence of): Sequentially list conditions Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last PROVED BY Y CERTIFICATIO Due to (or as a consequence of) IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 Tyes

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

MD

Funeral

Director

28a-f show

Director

Funeral

2

Completed

Be ပ unk

?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Evorument caust by rectified at

72 hours after

filed withir Hygiene.

12 should be fill h and Mental H is marked oth

permit. Pages 1 and 2 s. Department of Health ar Important: If item 27 is any Injury or other traus

Saltimore, Maryland 21215-0036

burial-trar the as page

law requires that the death certificate be executed

Box 68760.

P.0.

Records,

Division of Vital Hospital or Attending Physician:

death.

ner Exami physician Physician/Medical attending p signed by the a þ Completed peen has certificate Be ို this After thi Certification: within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

25. Was case referred to medical examiner? 1⊠Yes 2□No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide

5 ☐ Pending investigation 6 ☐ Could not be

Date of Injury (Month, Day, Year) MAY 19 2009 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ROAD

and manner stated.

Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work? 4:58 1 ☐ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred AUTOMOSILE ACCIDENT

26. Place of Death (Check only one)

BALTIMONE,

28f. Location (Street and Number or Rural Route Number Rd City or Town, State) 7560 Bel Air Bathmore, mo

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier

29a, Certifier

Medical

State Registrar

29c. License number RES-000 29d. Date signed (Month, Day, Year)

21224

2009

JUNE

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GALAMIS CHARLES

M.D. 4940 EASTERN AVENUE 32. Registrar's Agnatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amend 10d,10f, 19b, perfh g894 Certificate of Death

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** RYAN 98 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gensis Nursing Home Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🎛 F Director 101 220-30-6706 27 1907 ი7 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show ed other than "natural", or items 23a or 28a-f shore event, the Worldest Evan ing the natified at 1 LYes 2 □ No Director Baltimore MD NA 10g. Citizen of What Country? 10e Street and Number 1626 Division Street 6617 Eberle Drive Apt 21215 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2 **2√** No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 ¬No Specify: \$ Specify: 3√ Widowed 4 □ Divorced Black Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hutzlers Dept. Store 12th grade na Salesperson marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fi and Mental H Blanche Hill Alexander Nelson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21216 2502 W. Lanvale Street 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s' of Health a Nelson Matthews-Nephew 201, Eberle Drive Apt Baltimore, Md Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Pages Department of Important: If It any injury or o Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King Memorial Park 6/25/09 Woodlawn, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ATHEROSCIEROTIC CARDIOVASCULAR DISEASE YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off. executed burial-tran Due to (or as a consequence of): Box 68760, attending physician The law requires that the death certificate be Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ■ No for Month Day 5 Other (specify) P.O. the s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has by page 2 s autopsy performe certificate 1 ☐ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After th funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide the Hospital 1 De Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and D31136

State Registrar SRIAN
31. Date filed (Month)

9005 KILBRIDE RD, BALTIMORE, MD 21236

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lucia

State of Maryland / Department of Health and Mental Hygiene 2009

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** JUNE 2009 04:35 A™ ROSEN IRVING /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE GILCHRIST HOSPICE CARE TOWSON If Under 1 Year | If Under 24 Hrs. Birthplac Country) MD 8. Date of Birth Month, Pay, Year) 06-14-1925 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1 M 2 □ F 84 216-18-4800 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if then 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Exeminar 2000. 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ∐Yes 2 Mg No Director TIMONIUM MD BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21093 USA 12251 ROUNDWOOD ROAD, APT.204 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 💢 Married 1 □Yes 2 No Specify. Specify. <u>ک</u> WHITE 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) COMMERCIAL Elementary/Secondary (0-12) College (1-4or 5+) REALTOR REAL ESTATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **BLUM** BERNARD ROSEN GERTRUDE ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12251 ROUNDWOOD ROAD, APT.204, TIMONIUM, MD 21093 LOIS ROSEN / WIFE 20b. Place of Disposition (Name of A Reeman Place)
CHIZUK AMUNO 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/19/2009 BALTIMORE, MD SOL LEVINSON & BROS., INC. 22. Name and Address of Facility Signature of Puneral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Sm ome Approximate Interval Between Onset and Death Tirt1. Enter the disease, or compile a lors that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) STROKE 1)A48 **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): that the death certificate be executed sician and burlal-trans Due to (or as a consequence of): attending physician for use as the burla Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Ö 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ ARTERY DISEASE 1 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐Yes 2 ☐ No 1 ☐Yes 2 No Division of Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Hospital or Attending 1 X Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No after death

Director: / 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific D64395 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 N CHARLES ST. SUITE 209 BALTIMORE, MD 21204 DANIEUE DOBERMAN, MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 19 **Physician** Idell Rist Barbara 5:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Randallstown 10017 Liberty Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/9/1948 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign **Funeral** Months Days Hours Min. Mary land 1 M 2 X F 217-50-7201 60 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Michael Examination at Director Randallstown 1 ☐ Yes 2XXXVo MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21133 10017 Liberty Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14 Race - American Indian. 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 White 1 □Yes 2√XNo Specify: ģ 3 Widowed 4 Divorced Completed Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Media once. (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Retail Cashier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anita Grace Meekins Charles George Rist ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6500 Old Harford Road Baltimore, MD 21214 19a. Informant's Name/Relationship (Type. Print) Richard Rist / Brother 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Serv. Corp. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 6/22/2009 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Towson, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** nnoth disease or condition resulting in death) /Medical Due to (or as a consequence o) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Tyes 2 X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner-of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐Yes 2 ☐ No after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier und

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

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charles St. Dolto. md Zizay

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

Bonc

32. Registrar's Signature

	1 - State of Maryland	/ Department of Health and I Certificate of Death	Mental Hygiene	2009 [990]
Dhuaisian	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day	3. Time of Death
Physician /Medical	Marshall Clayton Roop, Jr.		June 18, 2	009 ^{Year} 2:55 p ^M
Examiner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		ounty of Death
	Gilchrist 5. Social Security Number 6. Sex 7. Age (In yrs. la.	Towson st hirthday) If Under 1 Year If Under 24 Hrs.		1timore 9. Birthplace (State or Foreign
Funeral Director	118-26-8631 1 ¹ M 2□ F 77	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 1, 193	1 Maryland
p 2	Usual Residence of Decedent 10a. State 10b. County 10c. City.	T		
taryla shov		Town or Location		10d. Inside City Limits 1 □ Yes 2 ☑ No
the N	Maryland Baltimore Ti	monium 10f. Zip Code	10a. Citize	n of What Country?
3a or st be	14 Spyglass Court	21093		.S.A.
21215-0036 within 72 hours after death with the Maryland iene. than "natural", or items 23a or 28a-f show he Medical Evaninar must be notified at ompleted by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		. Race - American Indian,
36 after or its	1 ☐ Never Married 2 💢 Married 1 ☐ Yes 2 💢 No If Yes, Give	1 ☐ Yes 2 🕅 No Specify:	1	Black, White, etc. pecify: White
hours a tural", o	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	16a. Decedent's Usual Occupation		
ed within 72 hou sygiene. The Medical Et, The Medical Et, The Medical Et,	15. Decedent's Education (Specify only highest grade completed)	(Give kind of work done during most of work life. DO NOT use retired)	king 166. Kind	of Business/Industry
212 d with giene ar than	Elementary/Secondary (0-12) College (1-4or 5+)	Executive		facturing
nd be file d othe svent,	17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, Maiden Su	ırname)
yla ould to Meniarked lastice lastice	Marshall Clayton Roop	Sara		rritt
Mar 12 sh th and 7 is m traum	19a. Informant's Name/Relationship (Type. Print) Barbara Lynn Roop/Wife	19b. Mailing Address (Street and Number or Ru	ral Route Number, City or T nonium,Md。 2	
1 and 1 and				tion - City or Town, State
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Eventiner must be notified at once. To Be Completed by Funeral Director		ce of Disposition (Name of netery, crematory or other place) top Service Corp. 6/23		n, Maryland
altii	21. Signature of Funeral Service Licensie	22. Name and Address of Facility		1050 York Road
Bal permi Depa Impo any ir	morald Rush	Ruck Towson Funeral		
	23a. Part 1. Enter the disease, or complications that cause the death, shock, or heart failure. List only one cause on each line.	Do not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
Physician	Immediate Cause (Final disease or condition a. Septimental a. Sept	515		Oncet and Death
/Medical Examiner	Due to (or as a conveque	nce of):	Of Cark	
e e	Sequentially list conditions,	nce on:	et foot en diseas	weeks
executed in and lal-transit	Sequentially list conditions, it is a better Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events	Theral Unscul	er diseas	e Jean
cate be executed physician and the burlal-transit dical Examir	resulting in death) Last Due to (or as a conseque			
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eath certific attending p for use as	IF FEMALE: 23c. If yes, outcome of pregnant	N/		
hat the death certified by the attending letached for use as Physician/Me	23b. Was decedent pregnant in the past 12 months? 1	leath 3 Ectopic pregnancy	23	d. Date of delivery Month Day Year
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ne law requires that the de shas been signed by the age 2 should be detached impleted by Physic	Part II. Other significant conditions contributing to death but not result	ng in the underlying cause given in Part I.	23e. Did tobacco use	contribute to the cause of death?
w requir been s should	CON ON MY MY TO CO	seasi	1 ☐ Yes 2 ☑	No 3 Probably 4 Unknown
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sician: T certificat rector, pa	25. Was case referred to medical examiner? Hospital: Hospital:	Other	th (Check only one)	
ding Physical After this of funeral direction: To	1 Inpatient 2 E	R/Outpatient 3 □ DOA Other 4 □ Nursing H 8b. Time of lnjury 28c. Injury at Work?	ome 5 Residence 6 28d. Describe how injury of	
ath. r: Afte e fun	1 ☐ Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident investigation	Injury Work? M 1 □ Yes 2 □ No		
tal or Attending Prais after death. al Director: After ted in by the funera Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	e, farm, street, factory, office	28f. Location (Street and I City or Town, State)	Number or Rural Route Number,
ital o rral Di lled in				
To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as Medical Certification: To Be Completed by Physician/Mer	29a. Certifier (Check only one) Medical Examiner: On the basis of examination and manner stated.	edge, death occurred at the time, date and place on and/or investigation, in my opinion, death occu	, and due to the cause(s) a rred at the time, date and p	nd manner as stated. lace, and due to the cause(s)
o the o the o mple	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date	signed (Month, Day, Year)
F S F O	M Hother lale v	N D25205	Dn	218, 2009
,	30. Name and address of person who completed cause of death (Item 2	3a) (Type, Print)	· 62 /	2/8, 2009
	Witt-Riley 6-BMC	2701 N. Chales	Jr. Balx	1. my 2030x
State Registrar	31. Date filed (Month, Day, Year) 32. Rigistrar's Signatu	A bould		

	1 = For State Registrar	State of Maryla		artment of Hertificate of D		, ,	iene eg. No. 20	9 19905
Physician (Madical	1. Decedent's Name (First, Middle	e, Last)	Si	mkin		2. Date of Death	h	3. Time of Death
/Medical Examiner	4a. Facility Name (If not institution The Johns Hopkins	s Hospital		4b. City, Town, or L Baltimore	City	•	4c. County of E	Death
Funeral Director	5. Social Security Number 162–28–1112 Usual Residence of Decedent	6. Sex 7. Age (In yr.	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 11/11/1	Year)	Birthplace (State or Foreign Country) New York
Maryland a-f show fied at	10a. State 10b. County	ngton 10c. (City, Town or Lo	ocation				10d. Inside City Limits
death with the Mary oms 23a or 28a-f sh r must be notified a		ng Road		10f. Zip-Code 22207		10	Og. Citizen of What	Country?
a # a .∃		If Yes Give		Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 🔀 No	spanic Origin? (Spe , Mexican, Puerto I Specify:	ecify Yes or No- Rican, etc.)	Black, V	American Indian, Vhite, etc. Caucasian
Z1Z15-0036 ed within 72 hours aft vgiene. ler than "natural", or ler than Medical Exami Completed by F		Year or Dates 1956 - nt's Education st grade completed) College (1-4 or 5+)	16a. Dece (Give life.	dent's Usual Occupat kind of work done du DO NOT use retired)	uring most of worki	ng	16b. Kind of Busin	ess/Industry
land 21;	17. Father's Name (First, Middle,	5+ Last)	Cura	tor Emerit	18. Mother's Name	e (First, Middle, I	Scienc Maiden Surname)	e
Maryla d 2 should th and Men if is marke traumatic	19a. Informant's Name/Relations	hip (Type. Print)	1	ng Address (Street a		al Route Number		
Ore, Nees 1 and of Health filem 27	Sharon R. Simk 20a. Method of Disposition 1 Burial 2 X Cremation	2015	Place of Dispo	nsition (Name of	-		20c. Location - City	inia 22207 v or Town, State
baltimore, Marylai permit. Pages 1 and 2 should b Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en	4 Donation 5 Other (\$ 21. Signatur / FuneranService		2	matory or other place Choices of Y 2. Name and Address 1205 Be11e	s of Facility 01		uneral C	
Physician /Medical	23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	complications that caused the de only one cause on each line. a. SEPSIS Due to (or as a const	ath. Do not en					Approximate Interval Between Onset and Death
Examiner	Sequentially list conditions,	b. FULMINANT	HEPAT	IC FAILURE		•		30 DAYS
st ou, sate be executed hysician and the burial-transit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. ACTINOMY Due to (or as a conse		FECTION		-·		30 DAYS
tificate be eg physician as the buri		d						
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit. Medical Certification: To Be Completed by Physician/Medical Examination:	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preg 1	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	f delivery Day Year
tures that the signed by uld be detailed by Pheed	Part II. Other Significant Conditi	ons contributing to death but not r	resulting in the	underlying cause give	en in Part I.	23e. Did tob	. 45	te to the cause of death?
The law requires ate has been sign page 2 should be						24a. Was an autops perform	y prio ned? dea:	e autopsy findings available r to completion of cause of th? Yes 2 \(\sum \text{No} \)
Physician: T Physician: T this certificate al director, pa	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2	☐ ER/Outpatier	Othor	26. Place of Death		nce 6 🗆 Other (Specify)
anding Pheath. or: After this he funeral he funeral cation: "attorn: "atto		gation	28b. Time o Injury	Work?	es 2 No		w injury occurred	
ital or Attending P Its after death. Its after death. Itel in by the funeration: Certification:		building, etc. (Spec	cify)			City or Town	State)	or Rural Route Number,
he Hospi in 24 hou he Funer pletely fill edical	(check only 2 Medical one)	ng Physician: To the best of my kr Examiner: On the basis of examination and manner stated.	nowledge, deatl nation and/or in	h occurred at the time evestigation, in my op	e, date and place, a inion, death occurr	and due to the cared at the time, d	ause(s) and manna ate and place, and	er as stated. If due to the cause(s)
To t Com	29b. Signature and title of certifie	3		29c. License r	number		June June	lonth, Day, Year)
	SAMUEL M.	who completed cause of death (If	1 3.0.	HADIKINICH	HOSPITAL 600 N	North Wol	fe St, Balti	more, MD, 21287
State Registrar	31. Date filed (Month, Day, Year) JUN 2 2, 2	009 Lewer A	fature far	Ris				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Item 23a State of Maryland Department of Health and Mental Hygiene Certificate of Death

Reg. No.

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 330 2009 06 07 /Medical 4a. Facility Name (If not institution aive street and number) 4b. City Town, or Location of Death 4c. County of Death **Examiner** Baltimore Kandallstown Hospita If Under 24 Hrs. 8. Date of Birth Month, Day 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1**X** M 2□ F MD Yrs. Director 08 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f show Baltimore MD Director 1 XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 21215 USA Dorithan Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Do If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, that any olones. College (1-4or 5+) y/Secondary (0-12) Ketall Maintenance Enguleer grada 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ullivan KODINSON Ellamead ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 21215 Sullivar 2 Kond Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Surial 2 Cremation 3 R 4 Donation 5 Other (Specify) 3 Removal from State Woodlawn Cemetery Woodlawn, MD C. Greene Funemesto 21. Signature of Funeral Service Lice Jav Rangallstown MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, su shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed as the burial-transi and Due to (or as a consequence of): Box 68760,7 Physician/Medical attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) Records, P.O. the detached 9 Unknown þ ins certificate has been signed director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? this certificate 1 ☐ Yes 2 ☑ No Division of Vital 2 Mo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident Investigation after death Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of leath (Item 23a) (Type, Print) W

State Registrar 31. Date filed (Month, Day,

Year)

JUN 2 2 2009

32. Registrar's Signature

			For State Registrar	State of Mary				Mental Hy	giene	9 19907
			1. Decedent's Name (First, Middle, La	st)		•		2. Date of Dea	ath	3. Time of Death
	Physici /Medi		CHARLES SA	NITH SR.				Month.	Day Yea 200	9 4:47PM
	Examir		4a. Facility Name (If not institution, given			4b. City, Town	, or Location of Dea	th	4c. County of De	
A.	-		HOW ARD COUNT	4 GONERIAL	INDERT	72 Co	LIMBIA		1 HEWY	420
	Funeral Director		5. Social Security Number 6. 8 259-32-3689	Sex 7. Age (Ir	yrs. last birth		ar If Under 24 Hrs 's Hours Min		y, $Year$)	irthplace (State or Foreign Country) EOTGIA
	pu »		Usual Residence of Decedent 10a. State 10b. County	110	c. City, Town	or Location				10d. Inside City Limits
	laryla i sho	5								1 □Yes 2 ₩ No
	the N	ect	MD Howard 10e. Street and Number		Laurel	L 10f. Zip Code			10g. Citizen of What	
	with a or	<u> </u>				20723			U.S.A.	Dournay:
	ns 23	Funeral Director	9614 Baltimore A	12. Was Decedent Ever	in II S		f Hispanic Origin?	Specify Ves or No.		nerican Indian,
"	fter d r iten	Fu	1 ☐ Never Married 2X Married	Armed Forces?	0.0.	13. Was Decedent o If Yes, specify Co		rto Rican, etc.)	Black, Wh	
93	urs a al", o	þ	3 ☐ Widowed 4 ☐ Divorced	1⊠Yes 2 □ No If Yes, Give Year or Dates: 192	18-52	1 □Yes 2 K ÎN	o Specify:		Specify: W	hite
2-0	within 72 hours after death with the Maryland lene. than "natural", or items 23a or 28a-f show the Modical Exp. viling must be notilied at	Completed by	15. Decedent's E	ducation	16a. I	Decedent's Usual Occ	upation		16b. Kind of Busines	s/Industry
2	thin 7	du	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)		Give kind of work dor life. DO NOT use reti	red)	orking	United St	ates
7	ed wi	ပ်	6		She	eetmetal W	orker		Governmen	t
g	be fill d oth even	Be	17. Father's Name (First, Middle, Last)					Maiden Surname)	
<u>y</u> la	ould Mer narke	ပို	Curby Smith, Sr.		-		Thelma	Ganus		
Jar	2 sh h and r is m		19a. Informant's Name/Relationship (-			er, City or Town, State	
6,	l and Health		Katherine V. Smi 20a. Method of Disposition						Maryland 2	
Baltimore, Maryland 21215-0036	Pages nent of I ant: If ite ury or o		1 X Burial 2 ☐ Cremation 3 ☐	nemoval nom State	cemetery	Disposition (Name of crematory or other p	lace)	Date	20c. Location - City of	or Town, State
뜶	it. Pa rtmel rtant njury		4 □ Donation 5 □ Other (Specif		Maryla			19,09	Laurel, Ma	aryland
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Madical Examination must be notified at once.		21. Signature of Funeral Service Liver	1///	100772	22. Name and Add Donaldso	n Funeral	Home, P	.A.	0707 4200
			23a. Part 1. Enter the disease, or com	plications that caused the	400773				Maryland 2	
	Dharaisian		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.				ic or respiratory at	11631,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a AWTE 1			MANURE			5 days
1	Examiner			Due to (or as a co		,	IAN EX	FUSION		34004
		ē	Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co			une of	1051014		700000
	cuted Id ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	BRONZ	INZ GN	ric luni	CHARL	EV.		3 weeks
oʻ	e exe an ar irial-ti		resulting in death) Last	Due to (or as a co						
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	ical		d						
3	ertifica ing ph	Physician/Med	IF FEMALE:							
Box 6	leath certific attending p	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐		3 ☐ Ectopic pregna	ncy		23d. Date of o	•
0	at the dea I by the a stached fo	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time 9 ☐ Unknown	e of death	5 Other (specify)			Month	Day Year
P. O.	hat the det by detacl	듄	Part II. Other significant conditions of	ontributing to death but no	t resulting in t	he underlying cause of	vivon in Port I	23e Did to	phaces use contribute	to the cause of death?
Records,	signed be det	δ	Currons c vist		ULMS		GASE	186		Probably 4 ☐ Unknown
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æ	sician: The law certificate has b irector, page 2 s	ם	Office of the	1767	illit?	Lin		24a. Was autop	an 24b. Were prior to death	autopsy findings available o completion of cause of
	n: Th ficate r, pa		OF Was assessed to a start					1 □ Yes	2 ₩6 1 Ye	s 2 4No
5	slcia certi recto	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:			thor:	ath (Check only o		
ō	Physer this sral di	Ë	27. Manner of Death	28a. Date of Injury	2 LER/Outp	allelit 3 DCA	4 ∟ Nursing i		dence 6 Other (Sp now injury occurred	pecify)
o	th. : After s funer	흲	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Yea	ar) Inji	ury W	ork? □Yes 2□No	EGG. BOOGNEST	iow injury occurred	
Division of Vital	al or Attend after death Director: , d in by the f	ij	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - building, etc. (S)	At home, farm	I n, street, factory, office			Street and Number or	Rural Route Number,
ā	urs afteral or ral Dir	Certification: To						City or Tow	,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p	Medical	29a. Certifier 1 ► Certifying Ph (Check only one) 2 ☐ Medical Exan	ysician: To the best of my niner: On the basis of exa and manner stated.	/ knowledge, mination and/	death occurred at the or investigation, in my	time, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	with To t	Ž	29b. Signature and title of certifier			_	nse number		29d. Date signed (Mo.	
			Levell	Landan		0	36974		Jun 15	, 2009
1	211		30. Name and address of person who							21524
1	<i>0</i> v		DAVO O NY 31. Date filed (Month, Day, Year)	ANTON ME		4 477101	ATUXENT	PARKIN	my Corum	BIA MO
	Sta	e	IIII O o good	32. Registrar's S	oignature	6				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** June 5, Albert F. Sisson 2009 1:48 A /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 ☑ M 2 □ F Director 216-20-3226 81 Aug. 9, 1927 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County show 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f shore event, the Medical Exerciting and the notified at Director Glen Arm 1 ☐ Yes 2 ☑ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11630 Glen Arm Road 21057 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?

Yes 2 \sum No permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any Injury or other traumatic event, the Medical Exaction 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1945–1946 1 ☐ Yes 2X No Specify: Specify: white \$ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industryunk 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Hugh J. Sisson Elizabeth Smucker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 627 Dunkirk Road Towson, Maryland 21204 Topher Sisson/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility State Anatomy Board 655 West Baltimore Street Baltimore, Maryland 21201 Mrector 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate use (Final disease or condition resulting in death) ang. **Physician** DIVATION /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, ner Due to (or as a surroughence of) tany, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Exami and Due to (or as a consequence of) burial-1 Records, P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) the detached þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð arrhosis 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy certificate perform Division of Vital 1 □ Yes this certific al director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To hospice After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) To the I within 2 29b. Signature and title of certifier D58303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St TONSON MI) ires 610 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

JUN 22

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 8, 2009 9:20 Howard Stein A M 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery Birthplace (State or Foreign Country) 5. Social Security Number unk 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1⊠M 2□ F Months Days Hours 3, 63 1946 Jan. Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Montgomery Silver Spring 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 433 University Boulevard 20901 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) disabled 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last)unk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tom Goss/friend 5037 Kansas Avenue NW Washington, DC 20011 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of the Property Service I censee Rona S Rona I 22. Name and Address of Facility State Anatomy Board 655 West Baltimore Street Baltimore, Maryland 2120 2 a. Par 1. Enter the disease, or collolications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest short or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery Ectopic pregnancy Month Day Year Other (specify) derlying cause given in Part I.

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

ed other than "natural", or items 23a or 28a-f show event, the Medical Examinant to method at

If item 27 is marked other than "r

t of Health a

Department of Important: If it any injury or conce.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

10a. State

MD

Director

Funeral

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Completed

Be ၉

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Physician/Medical <u>Ş</u> Completed Be Certification:

Division of Vital Records, P.O. Box 68760,

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □ I 5 □ (
Part II. Other significant condition	s contributing to death but not resulting in the	he und

proprili	appos	 CHY	_
			-

1	23e. Did tobacco use contribute to the cause of death?
Į	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
	24a. Was an autopsy findings available prior to completion of cause of death?

25. Was case referred to medical examiner?
27. Manner of D ath

Name and address of person

29a. Certifier

Hospita	1 Inpatient		ER/Outpatient	3 🗆 [AOC
28	a. Date of Injury (Month, Day, Ye	ear)	28b. Time of Injury		28c.

[AOC	Other:	4 Nursing H	ome	5 Residence	6 ☐ Other (Specit
	28c.	Injury a	t	28d.	Describe how inj	ury occurred

Natural Natural	5 Pending	(Month, Day, Year)	Injury
2 🗖 Accident	investigation		
3 🗌 Suicide	6 ☐ Could not be	28e Place of Injury - At he	ome farm street
4 ☐ Homicide	determined	28e. Place of Injury - At he	(v)

М	1 ☐ Yes	2 □No	
factor	y, office		28f. Location (Street

26. Place of Death (Check only on

6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specif	me, farm, street, facto	ery, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)
1 Certifying Physic	cian: To the best of my kno	wledge, death occurre	ed at the time, date	and place	e, and due to the cause(s) and manner as stated.

(Check only one) 2 Medical Examiner: On the basis of examination and/or investige and manner stated.	pation, in my opinion, death occurred at the time	e, date and place, and due to the cause(s)
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)

29c. License number			
1110	7	ì	

9d.	Date signed (No	nth	, Day,	Year)			
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	2/	<i> </i> `	~ /	0	V	V	1

	State
Rea	istra

Medical

Date filed (Month, Day,

death (Item 23a) (Type,	Print)
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rar's Signature	
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-/	6	/10/	2009
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3. Time of Death

10d. Inside City Limits

White

6 Months

June 19, 2009

1 X Yes 2 No

12:00 PM

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

	d			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 M No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 Ectopic pregnancy 5 Other (specify)		Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in	the underlying cause given in Part I.		ntribute to the cause of death? 3 X Probably 4 □ Unknowr
			_	Were autopsy findings available prior to completion of cause of death? □
25. Was case referred to medical examiner? 1 ☐ Yes 2 【 No	Hospital: 1 ☐ Inpatient 2 🛣 ER/Ou	Othor	Death (Check only one) g Home 5 ☐ Residence 6 ☐ C	Other (Specify)
27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. T	ime of jury at Work? M 1 □ Yes 2 □ No	28d. Describe how injury occi	
3 Suicide 6 Could not 4 Homicide determine		m, street, factory, office	28f. Location (Street and Nur City or Town, State)	mber or Rural Route Number,
29a. Certifier (Check only one) 1 Certifying F	Physician: To the best of my knowledge aminer: On the basis of examination an and manner stated.	, death occurred at the time, date and p d/or investigation, in my opinion, death o	lace, and due to the cause(s) and accurred at the time, date and place	manner as stated. e, and due to the cause(s)
29b. Signature and title of certifier	1	29c. License number	29d Date sini	ned (Month: Day Year)

67258

9707 Medical Center Drive, Rockville, Maryland 20850

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Nicholas Farrell, M.D.

JUN 2 2 2009

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- For State Amend #1 & 26, per MD g892 6/22/19 TT Registrar

Registrar

Registrar

Registrar Reg. No. Raymond Starr 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 10:45A JUNE 2009 16 WWW /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SLADE AVENUE, #401 PIKESVILLE BALTIMORE If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 05/05/1940 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1 🗓 M 2 🗆 F Months 500-42-7363 69 MD Director Usual Residence of Decedent 10h County 10c, City, Town or Location 10d. Inside City Limits 10a State 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 🙀 No Director MD BALTIMORE **PIKESVILLE** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2 should be filed within 72 hours after death with 1 n and Mental Hygiene. USA 21208 1 SLADE AVENUE, #401 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Tes 2 XIII Yes, Give Year or Dates: 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🌠 No <u>م</u> Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) **PROFESSOR** EDUCATION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RAYMOND **STARR** HORTENSE DAVIDSON ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other tra JANICE STARR / WIFE SLADE AVENUE, #401, PIKESVILLE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) HAR SINAI 06/19/2009 OWINGS MILLS, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. of Funeral Service 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician mentho disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760, sate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 9 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy performed certificate 1 ☐ Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Spec 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending investigation To the Hospital or Attendin within 24 hours after death.
To the Funeral Director: Aff completely filled in by the fur 1 ☐ Yes 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce 29c. License number 30. Name and address of

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 7 per fh g892 6-22-09 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) FRRY **Physician** SENADA 2009 /Medical 4c. County of Death ocation of Death 4a. Facility Name (If not institution, give street and number) Examiner ettehealth & Rebobilation Center If Under 24 Hrs. 6. Sex **Funeral** 1 □ M 2 F Director Usual Residence of Decedent Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City. Town or Location ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Funeral Director 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White etc Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any injury or other traumatic event, the Medical Examiner. once. 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 þ 3 Widowed 4 □ Divorced 15. Decedent's Education
(Specify only highest grade completed)

//Security (0-12)

College / Completed 16b. Kind of Business/Industr 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Fastier's Name (Firet Middle, Last) Be 19b. Mailing Address (Street and Namber or Rural Boute Number, City or Town, State, Zip Code) nant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of 20a. Method of Disposition 1 Burjal & Cremation 3 Removal from State 5 Other (Specify) 4 □ Donation 21. Signature of F neral Service Licenses disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Approximate Interval Between Onset and Death a ... Enter the diseas s ...ck, or head failure. nm diate Cause (Final di ease or condition esulting in death) days hysician MUCERTI /Medical Due to (or as a consequence of): Examiner noestive if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Therosc Hospital or Attending Physician: The law requires that the death certificate be executed ecc515 Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🗷 No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1☐ Yes 2 7 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 1 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death e Funeral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 14 Novem MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 50 Dolphn Street, Balthmare 31. Date filed (Month, Day, State Registrar

			1 - State of Maryland / Pepartment of Health and Mental Hygiene Certificate of Death Reg. No.	2009 19913
	Di		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day	3. Time of Death
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			Good Samantan Hospital Saltimore City	Saltimore City
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 June 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1 M 2 June 1 June 2 June 3 June 2 June 3 J	Birthplace (State or Foleign Country)
	Director		215-78-7175 1 M 2 M F 50 Yrs. World Bays Hours 66/08/1958	Maryland
	and		10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	Mary f sh	φ	Baltimore	1 🛛 Yes 2 🗌 No
	the 28a	Director	10e. Street and Number 10f. Zip Code 10g. Citiza	en of What Country?
	3a o	<u>_</u>	4722 Eugene Avenue 21206 U.S.	Α.
	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the "natical Everenes rout Le neiffied at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)	4. Race - American Indian, Black, White, etc.
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Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any figury or other traumatic event, the "faction Examiner mat to notified at once.		, , ,	eation - City or Town, State
30	Pages nent of I ant: If ite ury or o		1 \(\mathbb{R}\) Burial 2 \(\text{Cremation}\) 3 \(\mathbb{R}\) Removal from State 4 \(\text{Donation}\) 5 \(\text{Other}\) (Specify) Parkwood Cemetery 06/05/2009 Balt	imore, Maryland
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ă	permit. Departimont any Inj	0 0	Some Blue 5305 Harford Road, Baltimore,	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,	Approximate Interval Between
L.	Physician	r r	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a HYPONIC BRAIN MJUR	Onset and Death
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u u	ding Physician; The I h. Affer this certificate he funeral director, page	ü.	27. Manner of Death 1 Anatural 5 Pending 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury 28d. Describe how 28d. Describe how 28d. Describe how 28d. Describe how 28d. Describe how 28d.	occurred
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Division of Vital Records,	or At after of Direct in by	Certification: To	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and building, etc. (Specify)	Number or Rural Route Number,
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	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. Or the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as t	Medical	(Check only one) (Check only one) (Check only one) (Check only one)	
	o the vithin o the complete co	Me	29b. Signature and title of certifier 29c. License number 29d. Date	e signed (Month, Day, Year)
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			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Blvd
			Eyasu A. Melconer D64312 Ju 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 LUCK Raven Eyasu Mekonen MD Bauto Mo 2123	501.
h	Sta		te 31. Date filed (Month, Day, Year) 32. Hegistrar's Signature	
	Registr	ar	ar UIN 1 9 2009 Dener B. Frances	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Items 23art1,11,25,27,28a-1 per me, 8892,06/19/09dhb Registrar Certificate of Death Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1:05 PM Phillip C. Tisdale JUNE 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Union Memorial Hospital Balto 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1-5-1955 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. MD 54 213-62-4131 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Michael Exprine Lines the natified at once. MD N/A 1 X Yes 2 □ No Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1213 Rossiter Avenue 21212 TT S Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled 9th grade Disabled N/A18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ivory Tisdale, Sr Annie Mcknight 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Neaja A. Johnson-Daughter 8633 Trumps Mill Road Rosedale, MD 21237 20a. Method of Disposition

1 Burial 2 Decremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 6-16-2009 Greenmount Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD21202 Jane a Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ANOXIC BRAIN INJURY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner COCHINE OVERDOSE Sequentially list conditions Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). TION APPROVED BY ME HEMORRITAGE SUBARACHNOLD attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) ☐Yes 2☐No signed by the 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 M No After this certificate 1 □Yes 1 ☐Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury Formal Day, Year) 06/04/2009 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After Found: p_M 1 ivi vatoral 5 Pending Unknown 1 ☐ Yes 2X No investigation 2 Accident the 6 XCould not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Unknown Unknown 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AT-2438946 M.D. JUNE 07, 2009

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31. Date filed (Month, Day, Year)

JUN 19 2009

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HOSPITAL , BALTIMONE MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DATE M.D. UNION MEMORIAL
Day, Year) 32/Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #18 Per FH G892 6/22/09 JH State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1030 PM EDITH S. TIETZER 2007 mo /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE SEASONS HOSPICE@NORTHWEST HOSPITAL RANDALLSTOWN If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year, 08/18/1919 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 € F 057-03-6491 89 NY Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. Medical Examine Linust be rediffied at once. MD 1 □Yes 2 No BALTIMORE OWINGS MILLS Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 4730 ATRIUM COURT. 21117 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 WHITE 1 □ Yes 🎾 No Specify Specify þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) UNITED STATES Elementary/Secondary (0-12) College (1-4or 5+) POSTAL SERVICE SECRETARY 18. Mother's Name (First, Middle, Maiden Surname) Be (17. Father's Name (First, Middle, Last) UNKNOWN Kalikovsky MAX SADOWSKY PAULINE ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) OWINGS MILLS, MD 21117 ALLEN TIETZER/SON 267 CEDARMERE CIRCLE 20b. Place of Disposition (Name of BETHYEHUDA ANSHE KURLAND 20a. Method of Disposition

XX Burial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State Date 06/19/2009 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS 21. Signature of Funeral Service Licenses INC. 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 10000 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (or as e consequence of): Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consecuence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 WNo 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1105 16 Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 M Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 1835 Smith Avenue Suite 203 Baltimore MD 21208 ton 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Robert Williams Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. UNK UNK State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month 1915 hrs Medical Examiner June 1, 2009 ROBERT 4a. Facility Name (if not institution, give street and number) 4c. County of Death Baltimore 1943 Mosher Street If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5 Social Security Number 6. Sex Funeral Foreign Country) MARYLAND Months Hours Director 213-78-0294 1 X M 2 Usual Residence of Decedent 10d Inside City Limits Ioc. City, Town or Location 10b County 1 X Yes 2 BALTIMORE MARYLAND permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Director 10g. Citizen of What Country? 10e Street and Number 1938 SHER STREE mo Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married 2 Married 2 X No Yes Specify: BLACK Yes 2 No specify: 4 X Divorced If Yes. Give Year <u>۾</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12TH GRADS ELECTRICIAN BALTIMORE CITY 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) KENNED4 SILKINS æ RADY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 302, BALTO, MD 21215 3323 LIBERTY HIGHTS, APT. WILKINS If item 27 (MOTHER) 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date 20a, Method of Disposition 1 Burial 2 Cremation 3 Removal from State 122/2009 BALTIMORE, MARYUANT MEMORIAL PARK 06 Donation 5 Other Specify. 22. Name and Address of Facility

SOSEPH H. CROWN JR. FUNERAL HUME

SOSEPH H. CROWN JR. FUNERAL HUME 21. Signature of Funeral Service Licensee Tying, such as cardiac or respiratory arrest, shock, or heart

Approximate Interval TUK 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. /Medical Death a. Head Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Discass or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical AMENDED UNPENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown ncate has been signed by the page 2 should be detached for 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 No 3 Probably 4 ✔ Unknown Cocaine use Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autonsy After this certificate has performed? death? 1 🗸 Yes Yes 2 No 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Other₄ examiner? Nursing Home 5 Residence 6 🗸 Other: Scene Inpatient 2 ER/Outpatient 3 ٩ 1 🗸 Yes 28a. Date of Injury FOUND: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Unknown FOUND: Natural To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Yes 2 V No Pending filled in by the Jun 1, 2009 1915 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) 1943 Mosher Street, Baltimore , MD determined (Specify) Rowhouse Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

4

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

30. Name and address of person who completed cause of death (Item 23a)

Ana Rubio MD.

31. Date filed (Month

Assistant Medical Examiner

Registrar's Signatu

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

June 2, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year 2009 Ola harhes 6 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Umm 8. Date of Birth (Month, Day, Year) 07/27/1954 5. Social Security Number Sex 1 M 2 □ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months 54 Texas 460-90-0965 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County Yes 2 □ No Martinsburg WV Berkeley 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 612 Albert Street 25404 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Vietnam Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married 1 □Yes 2 No White Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) French Gladys Sqt. James O.D. Wiggins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 612 Albert Street, Martinsburg, WV 25404 Rebecca Stirman Wiggins, Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 06/19/2009 Martinsburg, WV Green Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brown Funeral Home 21. Signature of Funer | Salvice Licensee T. Harman 327 West King Street, Martinsburg, WV 25402 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a. Acute Myccardial Due to (or as a consequence of): disease or condition resulting in death) Dus to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Abdominal Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) _ 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the y 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐Yes 2 No 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Evanings must be notified at

"natural",

is marked other than

Department of Health ar Important; If item 27 is any injury or other trauonce.

Director

Funeral

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Completed

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner burial-transit attending physician and for use as the burial-tran cate has been signed by the page 2 should be detached certificate Certification: To this After t within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 1 Yes 2 □ No 27. Manner of Death

29a, Certifier

(Check only one)

Physician/Medical 23b. Was decedent pregnant Completed by 25. Was case referred to medical examiner? Be

1 □ Natural 2 Accident 3 ☐ Suicide 4 Homicide

5 Pending investigation 6 ☐ Could not be

1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 6-3-2009

and manner stated.

28b. Time of UNIC

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Street

28c. Injury at Work? 1 Yes 2 □ No

29c. License number

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Green St Baltimore, MD

28d. Describe how injury occurred Rolled over by Tractor Trailer 28f. Location (Street and Number or Rural Route Number City or Town, State)

Interstate 70 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The first of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

AU 417643519517

29d. Date signed (Month, Day, Year) June 17, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANTON GUEORGUIEV

32. Registrar's Signature

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 45 PM THUR WILKENS 09 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death Examiner TH WE 100P KANDALL STOWN
If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Year) Months Days Hours Min. **X**□ M 2 □ F Yrs. 219-01-5549 Director 19 90 03 19 MD Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Midical Examiner must be notified at 1 ☐Yes 2 No Director Pikesville Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21208 U.S.A. 8342 Scotts Level Road 23a Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☐ No Specify: Ş Specify: 3 ₩ Widowed 4 Divorced Black "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Hygiene. and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Coppin State College Custodian 12th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Rose Henson Austin Wilkens ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other trau 8342 Scotts Level Road, Pikesville, Md 21208 Rose Wells-Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 Durial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Garrison Forest Vet 6/26/09 Owings Mills, permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Plastuan heumohia /Medical Due to (r as a consequence of): Examiner mente Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and burial-trar resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Year Month Day 5 ☐ Other (specify) P.0. ed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ № 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy performed 1 □ Yes 2 🗐 🛚 1 ☐ Yes After this certification, g Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 No 2 Accident hours after death the 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a Hospital 19 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely (Check only one) 29b. Signature and title of certiffe 29c. License number 29d. Date signed (Month, Day, Year) D006332 200

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

. Registrar's Signatu

HMANOBE

31. Date filed /Me

Year)

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of rtificate of			jiene _{leg. No.} 2009	19919
	Dhari		1. Decedent's Name (First, Middle	Last)				2. Date of Dea Month	th	3. Time of Death
	Physic /Med		WINFRED C. ALL					JUNE 3,	2009 Year	1435 ™
	Exami	ner	4a. Facility Name (If not institution				or Location of Death		4c. County of Dea	
	Funera		MONTGOMERY GENE 5. Social Security Number		L CENTER ge (In yrs. last birthday	OLNEY If Under 1 Year		8. Date of Birth	MONTGOME I	rthplace (State or Foreign
	Director	_	227-34-2445	1 □ M 2 🕱 F	82 Yrs.	Months Days	Hours Min.	(Month, Day March 16	(Year) C	Ltimore, MD
	w.	1	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ncation				10d. Inside City Limits
	Marylan -f show Ked at	ţō	Maryland Montgo	ma r 11						Y Yes 2 □ No
	ith the Maryla or 28a-f sho	Director	10e. Street and Number	nery	Silver Sp	10f. Zip Code		1	0g. Citizen of What C	ountry?
	th wit	ra D	3810 Tynewick D	rive		2090)6	ι	Jnited Stat	tes
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ont, it is Modical Experiment must be rediffed at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? d 1 Tyes 2 1 If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of If Yes, specify Cul 1 □Yes 2🏗 No	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:	
2-0	72 hours "natural",	Completed	15. Decedent's (Specify only highest	Education	16a. Dece	dent's Usual Occu	pation	ina	16b. Kind of Business	/Industry
121	be filed within 72 hortal Hygiene. d other than "natu event, the Medical	mple	Elementary/Secondary (0-12)	College (1-4or	0+)		during most of work			
d 2	al Hygie other t		12 17. Father's Name (First, Middle, L	ast)	Superv	isor of	Data Proc 18. Mother's Name		Government	
lan	Mental Mental arked o	To Be	Willie Jones	,			Mary Car		variour darriarro)	
ary	and sm	-	19a. Informant's Name/Relationsh	p (Type. Print)	19b. Maili	ng Address (Stree			r, City or Town, State,	Zip Code)
	ss 1 and 2 of Health litem 27 i		W. Patricia Gra	y / Daughte					ing, Maryla	
Baltimore,	iges 1 if ite or ot		20a. Method of Disposition 1X Burial 2 ☐ Cremation	B □Removal from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other pla	ace)	Date	20c. Location - City or	Town, State
ΙĦ	permit. Pages Department of Important: If is any Injury or once.		4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service L	(iff)	George Wa	ashingtor	1 6/10	/2009 A	Adelphi, Ma	aryland
Ba	Depart Impo		List C	M	0/100 55	538 Mar1h	oro Piko	e Funera Foresty	al Homes, l	P.A.
			23a. Part 1 Enter the disease, or o shock, or heart failure. List o	omplications that caused	the death. Do not en	ter the mode of dy	ing, such as cardiac	or respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	nly one cause on each ii	ne.	1.10) /	embely s		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	KAN / P	Menang C	erior pr		ho
н	_xammer	-e	Sequentially list conditions,	b. Care to by as	a const uence of):					yn.
	d d ansit	Examiner	Sequentially list conditions, if any leading to limite Jude cause. Enter Underlying Cause (Disease or injury that initiated events	200 (5) (2)	a sons sonos or,					
oʻ	e exec ian an ırial-tr	Exa	resulting in death) Last	Due to (or as	a consequence of):					
68760,	rificate be executed ng physician and as the burial-transit	edical	•	d.						
9 x	certifi nding	Me	IF FEMALE:	23c. If yes, outcome	of pregnancy				00d Date of the	
P.O. Box	Physician: The law requires that the death cert this certificate has been signed by the attending director, page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		2 Fetal death 3	☐ Ectopic pregnand ☐ Other (specify) _			23d. Date of de Month	Day Year
Records, F	w requires than been signed is should be det		Part II. Other significant condition	s contributing to death b	ut not resulting in the u	nderlying cause gi	ven in Part I.	m .	pacco use contribute t es 2 □ No 3 □ F	o the cause of death?
II Reco	rysician: The law r is certificate has be director, page 2 sh	Completed by						24a. Was al autops perforr 1 □ Yes	y prior to ned? death?	utopsy findings available completion of cause of
of Vital	i cian certific ector,	Be	25. Was case referred to medical examiner?	Hospital:		lo.	26. Place of Death			
ð	ding Phys h. After this funeral dir	7: To	1 Yes 2.☐No 27. Manner of Death	1 ☐ Inpatie	ent 2 ER/Outpatier	11 3LIDUA			ence 6 Other (Spenow injury occurred	ecify)
ion	nding ath. r: Afte e fune	atior	1 Natural 5 Pending 2 Accident investiga	(Month, Da	y, Year) Injury	Wor	rk?]Yes 2 □No	zou. Describe no	w injury occurred	
Division	Hospital or Attending 24 hours after death. Funeral Director: After stely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ury - At home, farm, str c. (Specify)	eet, factory, office		28f. Location (St City or Town	reet and Number or R n, State)	ural Route Number,
	To the Hospital of within 24 hours at To the Funeral D completely filled it	Medical C	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the best caminer: On the basis o and manner sta	f examination and/or in	h occurred at the t vestigation, in my	ime, date and place, opinion, death occurr	and due to the c red at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	Vithi Comp	M	29b. Signature and title of certifier	111	Med Dire	4		2	9d. Date signed (Mon	th, Day, Year)
	9		Valuet	K ins	Dept Em		0410		6/5/09	
0	<i>י</i>		30. Name and address of person w	no completed cause of d	eath (Item 23a) (Type,	Print)	1 11		000-	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	noe Philip	Dr Uln	eg Mi)	010832	
	Registr		JUN 0 9 2009	anna) B	ar's Signature					

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Physician
/Medical
Examiner

Direct

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other thaumatic event, if "Mentel Exercitivations the motified at Physicia /Medic

Baltimore, Maryland 21215-0036

Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Regi

	1. Decedent's Name (First, Middle, Last) MARGUERITE ADAMS	3	ADAMS	2. Date of Death Month	Day Year	3. Time of Death
4	- MARQUERITE - ADAMS 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of De	JUNE 4	2009 4c. County of Dea	9:00 A
	9955 GOOD LUCK ROAD # 204		LANHAM		PRINCE O	
	5. Social Security Number 6. Sex 7. Age (In s	rs. last birthday) Yrs.	If Under 1 Year If Under 24 F	lin. (Month, Day,	Year) 9. Bir	thplace (State or Fore
-	579-64-4360 59 Usual Residence of Decedent	113.		OCT. 29	1949 WAS	SHINGTON, D
	10a. State 10b. County 10c.	City, Town or Lo	ocation			10d. Inside City Lim 1X Yes 2 □
L	MD PRINCE GEORGE'S	LANHA				
ı	10e. Street and Number		10f. Zip Code		g. Citizen of What Co	ountry?
Н	9955 GOOD LUCK ROAD # 204 11. Marital Status 12. Was Decedent Ever in	1US 13	20706 Was Decedent of Hispanic Origin		USA 14. Race - Ame	erican Indian.
	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No		Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	uerto Rican, etc.)	Black, Whit	
	3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 No Specify:		Specify: BI	LACK
	15. Decedent's Education (Specify only highest grade completed)	I (Give	dent's Usual Occupation		6b. Kind of Business	/Industry
1	Elementary/Secondary (0-12) College (1-4or 5+)	`life.	DO NOT use retired)			
-	12TH 17. Father's Name (First, Middle, Last)	LEG	ISLATIVE SPECIAL	IST Name (First, Middle, M	GOVERNMEN aiden Surname)	NT'
	WILLIAM C. SMITH		DOROT			
-	19a. Informant's Name/Relationship (Type. Print)	19b Maili	ng Address (Street and Number of			Zip Code)
	TONI S. BROWN/DAUGHTER	I	METZerott road		-	
	20a. Method of Disposition	b. Place of Dispo	osition (Name of matory or other place)	Date 2	0c. Location - City or	Town, State
	i Buriai 2 kg Cremation 3 Li Removal from State			/6/2009	RIVERDALE,	MARYLAND
-	21. Signatu e of Fune Service Licensee	2		J. B. JENK	INS FUNERA	AL HOME
1	Ja /		7474 LANDOVER RO	AD LANDOVE	R,MARYLANI	
	23a. Part 1. Enter the disease, or complications that caused the d shock, or heart failure. List only one cause on each line.	eath. Do not en	ter the mode of dying, such as car	diac or respiratory arre	st,	Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) METASTAS	IS LUNG	CARCINOMA			Ondot and Down
ĺ	Due to (or as a cons					
100	Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying					
F	cause. Enter Underlying Cause (Disease or Injury that initiated events c.					
	resulting in death) Last C. Due to (or as a constitution)	sequence of):				
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-	23b. Was decodent prognant 23c. If yes, outcome of pre	etal death 3 [☐ Ectopic pregnancy ☐ Other (specify)		T.	,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 7:10 A M CARROLL **ADAMS** 2009 L. June 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Somerset McCready Memorial Hospital Crisfield 9. Birthplace (State or Foreign Country) Maryland if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 6, 1928 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday Hours Days 1 □X M 2 □ E 217-36-1211 80 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Somerset Marion Station 1 ☐ Yes 2X No Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21838 U.S.A. 27930 Farm Market Road 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 📆 No if Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☒ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Farmer Farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernest Adams Marie Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorraine Lankford (Companion) 27265 Cash Corner Rd.-Crisfield, MD 21817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Paul's Cemetery 4 ☐ Donation 5 Other (Specify) 6/12/09 Marion Station, MD 21. Signature 22. Name and Address of Facility Bradshaw & Sons Funeral Home Robert H. Bradshaw, Jr. 306 W. Main St.-Cristield, IM. 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 306 W. Main St.-Crisfield, MD Immediate Cause (Final disease or condition resulting in death) HEMO RRHAGE INTRACEREBRAL Due to (or as a consequence of): Sequentially list conditions, if trap, bearing to influentiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dun to (or 66 a nonsequience of) Due to (or as a consequence of):

Physician /Medical Examiner

the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

ģ

Completed

Be

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

death with the Maryland

burial-tran attending physician for use as the buria nas certificate To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral or

	d					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	aldeath 3⊟Ectopi	c pregnancy (specify)		23d. Date of delivery Month Day	Year
Part II. Other significant conditions co	ntributing to death but not res	sulting in the underlyin	ng cause given in Part I.	23e. Did	tobacco use contribute to the caus Yes 2∰No 3 ☐ Probably	se of death? 4 ∐Unknowr
						on of cause of
25. Was case referred to medical			26. Place of De	eath (Check only	one)	
examiner? 1 ☐ Yes 2 No	Hospital: 1 npatient 2 □]ER/Outpatient 3□	DOA Other: 4 Nursing	Home 5 ☐ Resi	idence 6 Other (Specify)	
27. Manner of Death 1 ★ atural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No		how injury occurred	
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, fac fy)	ctory, office	28f. Location (City or To	Street and Number or Rural Route wn, State)	e Number,
29a. Certifier (Check only one) 1 → Certifying Phy 2 → Medical Exam	vsician: To the best of my known iner: On the basis of examinated and manner stated.	owledge, death occur ation and/or investiga	red at the time, date and plaction, in my opinion, death oc	ce, and due to the curred at the time	e cause(s) and manner as stated. , date and place, and due to the ca	ause(s)
29b. Signature and title of certifier	1		29c. License number		29d. Date signed (Month, Day, Y	'ear)

00062172

EB

31. Date filed (Month State Registrar

29b. Signature and title of certifier

SHARAD

SATYAL Day, Year) IN 09

MI)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1604 MARKET ST POCOMORE CITY ND 32. Pegistrar's Signature

MD

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Bizzarri, Sr. Peter June 3, P M 7:05 2009 /Medical 4c. County of Death
Carroll 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examine Westminster Carroll Hospital Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1√2 M 2□ F 68 218-36-8715 Yrs Director 1941 Baltimore, MD Feb. Usual Residence of Decedent 10c. City, Town or Location Westminster 10d. Inside City Limits 10b. County id other than "natural", or items 23a or 28a-f show event, the Medical Evantiner must be notified at 10a. State Carroll MD Director 1 XYes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with U.S.A. 21157 4 Fox Meadow Garth Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 22 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Carpentry permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygient Important: If item 27 is marked other tha any injury or other traumatic event, Its.\) Carpenter 18. Mother's Name (First, Middle, Maiden Surname)
Catherine Hicks 17. Father's Name (First, Middle, Last) Be Robert Charles Bizzarri ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Fox Meadow Garth, Westminster, MD 21157 Betty June Bizzarri - Wife 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place Carroll Cremations 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Hampstead, MD 6/8/2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Pritts Funeral Home & Chapel, P.A. 21. Signature of Juneral Service Licensee als 412 Washington Rd., Westminster, MD 21157 23a. Part 1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** neymonia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed and Due to (or as a consequence of): burialphysician P.O. Box 68760 Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>۾</u> Ma 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has Hospital or Attending Physician: The certificate 1 □Yes P□No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes PINO 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 ☐ Matural 2 ☐ Accident 5 Pending n 24 hours after death.

In Funeral Director: After the further of the further than 10 the further 10 the further 10 the further 10 the further 10 the further 10 the further 10 the further 10 the further 10 the further 10 the further 10 the further 10 the 10 th 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Hosp within 24 hor To the Fune completely fi (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c, License number 6-4-09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Blvd westmins term of the property of the prope 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day May 30, 2009 **Physician** Joseph Patrick Bowers 7:00 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**K** M 2□ F Months Days Hours Min. 220-34-8845 70 Director March 6, 1939 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State ir than "natural", or items 23a or 28a-f show Director 1 ☐ Yes 2X No Maryland Montgomery Olney 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 17429 Monitor Drive 20832 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status filed within 72 hours after 1 K∑Yes 2 ☐ i If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Maryland 21215-0036 1 ☐ Yes 2/1X No Specify. Completed by Specify: 3 Widowed 4 ☐ Divorced 1957-59 White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Car Broker Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be s 1 and 2 should be fill f Health and Mental H Item 27 is marked oth other traumatic even Joseph Bowers Etha Weber ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph P. Bowers/son 17429 Monitor Drive, Olney, MD 20832 item 27 other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 permit. Pages
Department of I
Important: If ite
any injury or or 1 ☐ Burial 2 Kocremation 3 ☐ Removal from State June 1, Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home
500 University Blvd. W., Silver 21. Signature of Funeral Service Licensee Inc. Spring, MD 20901 23a. Part 1. Enter the disease, or computations that caused the death. Do not enter the *mode* of dying, such as cardiac or restratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Intracerebral Hemorrhage disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Status Post Fall Sequentially list conditions, if any, leading to immediate cause. Enter Univerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examine Physician: The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of) Physician/Medical 687 attending ph Вох IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year detached Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown filled in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? Was a.. autopsy performed? Ves 2 No 24a. Was an 2 🗆 No Vital 1 ☐ Yes 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 AYes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ™npatient 2 ☐ ER/Outpatient 3 ☐ DOA ot 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Division 1 ☐ Natural 2 Accident 5 Pending investigation 5/15/2009 1:00^M 1 ☐Yes 2X No Fell down stairs 24 hours after deat Funeral Director: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State).
18913 All Penglow Lane, Brookeville, MD 20833 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Home Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ٩ 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) greenbelt AEE 7525 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 04 JUN Registrar

			For State Registrar		State o	of Maryla		partmer <i>ertifica</i>		Health and N Death	Mental Hy	gien Reg. N	200	9	1992	
	Physici /Medic		1. Decedent's Name Louise	e (First, Middle, Hanbury		nn					2. Date of De Month June	ath 3,	^{0ay} 2009	ear	3. Time of Death	
	Examin		4a. Facility Name (I		_	ımber)		Bet	thes				o. County of I	mery		
	Funeral Director		5. Social Security N 579-40-	-8567	6. Sex 1 □ M 2 🖾 F		78 Yrs	Months	r 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Di Oct. 1	rth ay, Yea , 1	930 W	Count	ace (State or Foreigy) ngton, D	
	uryland show	_	Usual Residence of 10a. State	10b. County		10c.	City, Town or	Location				•		10	d. Inside City Limi	
	e Ma 8a-f s	Director	Maryland		Montgome	ry	Silve	r Spr								
	vith the	ä	10e. Street and Nur					10f. Zi	p Code			9	Citizen of Wha	at Count	ry?	
	ath v s 23a nust	<u>ra</u>		odson I						20902			USA	A ul	un Indian	_
Maryland 21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show Areal Examiner must be notified at	d by Funeral	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed	4 Divorced	If Yes, G Year or D	orces? 2 ፻ No ive		1 □ Yes	2 34 No	dispanic Origin? (Si an, Mexican, Puerto Specify:	o Rican, etc.)		Specify:	White, e	ite.	
215-(thin 72 h re. an "natu	Completed	(Spec		s Education t grade completed) College (-	16a. De	ecedent's Usu ive kind of wo e. DO NOT u	ial Occuj ork done ise retire	oation during most of worl d)	king	16b. 	Kind of Busin	ness/Indi	ustry	
21	ed wil	ပ္ပြ			4		Rec	jister	ed N				dical			
nd	be file tal H d oth	Be	17. Father's Name							18. Mother's Nam	, .					
yla	Men Men arke	ျ			Labofish	l					na T. F					
Mar	and 2 shealth and 2 27 is m		19a. Informant's Na Carl K		ip <i>(Type. Print)</i> nann/Husb	and				and Number or Ru on Lane,						
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, If a Medical Exagnee.				3 □ Removal from	State	b. Place of Dis cemetery, o Metropo			i 1J	une 3, 2009		Location - Cit		_{vn, State} Virginia	a
Balti	permit. Departn Imports any inju		21. Signature of Fu	uneral Service L	icensee			Franc	ris .	ess of Facility J. Collinersity Bl	s Funer	al Si	Home I	nc.	ng. MD 20	 090
1		7		art failure. List o	complications that	cause time deach line.	leath. Do not						75.7		Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause disease or condition resulting in death)				ry Fail	ure							24-36 hc	our
I	Examiner		roodiiing in dodiin				sequence of):								10 04 1	
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09 0325 AM 68760, 5	ficate be executed physician and s the burial-transit	edical Examiner	cause. Enter Unde Cause (Disease or that initiated events resulting in death) I	erlying injury s Last	U		nt Mido sequence of):	lle Cer	rebr	al Artery	Infarc	tio	on		72-100 h	10u
3-0c Box 68	death certificate be e attending physicia d for use as the buri	an/Medi	IF FEMALE: 23b. Was deceden		23c. If yes, ou	tcome of pre		3 ☐ Ectopic	pregnan				23d. Date of		*	
P.O. B	that the deal ed by the att detached for	Physician/M	in the past 12 1 ☐ Yes 2 2 ☐ Unknown	∑No		nant at time		5 Other (s					Month	1	Day Year	
~ 's	w requires that the death certif s been signed by the attending should be detached for use as	ρ	Part II. Other signif	ficant condition	ns contributing to d	leath but not	resulting in the	e underlying	cause gi	ven in Part I.					e cause of death? ably 4 ☐ Unkno	
Suise Vital Record	90 H C/I	Completed			.,						24a. Was auto perf 1 🗆 Yes	psy ormed	? prid	ere autor or to cor ath?]Yes	osy findings availal npletion of cause of	ble of
₹ E	fan: rrtifica	BeC	25. Was case refer	red to medical						26. Place of Dea						
و ح	ysice direc		examiner? 1 ☐ Yes 2 🔁	No	Hospital: 1 🔁	Inpatient 2	2 🗆 ER/Outpa	itient 3 🗆 D	Otl	ner: 4 🗆 Nursing H	ome 5 🗆 Res	idence	6 ☐ Other	(Specify	<i>'</i>)	
7 5	ng Pł fter tł neral	Ë	27. Manner of Deat	th 5 Pending	28a. Date (Mor	of Injury oth, Day, Yea	28b. Tim	e of	28c. Inju Wo	ry at rk?	28d. Describe	how in	njury occurred			
<u>S</u> . S	endil sath. or: A the fu	atic	2 Accident	investiga	ation			М	1 🗆	Yes 2 □No	_					
math, Division	al or Att s after de al Direct	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could n determin	ned 28e. Place	e of Injury - A ling, etc. (Sp	At home, farm, pe <i>cify)</i>	street, factor	ry, office		28f. Location City or To			or Rura	l Route Number,	
sergman Divisio	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical (29a. Certifier (Check only one)	1 Certifying 2 Medical E	examiner: On the	e best of my basis of exar nner stated.	knowledge, d mination and/o	eath occurre or investigation	d at the t	ime, date and place opinion, death occu	e, and due to th urred at the time	e caus , date	e(s) and mani and place, an	ner as s d due to	tated. the cause(s)	
36	Somptime Som	Me	29b. Signature and	title of certifier		R_	-			se number 8 68160		29d.	Date signed (Month,	Day, Year) 8 <u>3</u> 2 AN	^
			30. Name and addr Kimber	ress of person v	vho completed au	of death ((Item 23a) (Typ Old Ge	oe, Print) eorge to	own	Road, Bet	hesda,	MD	20814			
	Sta Registr		31. Date filed (Mon	ithi, Day, Year)	2009 1	Registrar's S	ignature.	ares								

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			For State		State	of Ma	aryland		partmei <i>ertifica</i>				ental Hy		001	0.0	10005
	7 11		Registrar 1. Decedent's Nam	e /First Middle	(act)			C	erunca	te or i	Jeam	<u> </u>	2. Date of De	Reg. No.	20	UY	3. Time of Death
	Physicia		i. Decedent 5 (turn		Victori	э М	D1:m	10					_{Month} June	Day 5	200	Year	5:50 A ^M
	/Medic Examin		4a. Facility Name (/				DIGI		4b. City	, Town, or	Location	of Death	Ounc	4c. County of Death			
	9		Manor Ca		ville					Rossv				Baltimore			
	Funeral		5. Social Security N		6. Sex 1 ☐ M 2 ☐ F	= ~	e (In yrs. li		rithday) If Under 1 Year If Under 24 Hrs. 8. Date of Birt (Month, Days Yrs. Hours Min. 0.3-1.9-						,	Coui	
£ 4	Director		189 05 7 Usual Residence of			9:	2						03-19-	-191		rem	nsylvania
	rylanc how	_	10a. State	10b. County			10c. City	, Town or	Location								10d. Inside City Limits 1 ☐ Yes 2 🛣 No
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	72 hours after death with the Maryland naturali", or Items 23a or 28a-f show dical Examiner must be notified at	Funeral Director	10e. Street and Nu 4665 Pal		'ourt				101. 2	ip Code 210	13					d Sta	
	seath	eral	11. Marital Status	OILLIIO C	12. Was D	ecedent	Ever in U.	S. 1	3. Was Dec			rigin? (Spe	ecify Yes or No Rican, etc.)		14. Race	e - Ameri	can Indian,
٥	or Iter	Fur	1 Never Marr	ried 2□ Marri		I Forces? es 2 X I Give				ecity Cuba	an, Mexica Specify		Hican, etc.)		Specify.	k, White,	
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7	be filed within 72 hours after death with the Marylan Hydlene. Ad althylene. ad other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	Elementary/Seco	ondary (0-12)	Colleg	e (1-4or 5	5+)		Hon	nemak	er			(Own I	Home	
and	be filed htal Hyg ed othe event,	Be C	17. Father's Name		Last)			-					(First, Middle,		Surnam	re)	
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Ē	it. Pages Intment of I Intrant: If Its njury or o			Cremation 5 ☐ Other (S _i	3 □Removal from the secify)	om State			. Crema		1	6-8-	2009	Hano	over	, MD	
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מ	89 E 29		Olan	n Orth	m- Wy	u			4112	old C	olumb	oia P	ike Ell	icot	ct C	ity,	MD 21043
	Ę.		23a. Part1. Enter shock, or head immediate Cause	art failure. List	complications th only one cause o	at caused on each li	the death ne.	n. Do not	enter the mo	ode of dylr	ng, such a	s cardiac	or respiratory a	rrest,			Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	on	a	to (or as	a consequ	uence of):	<u> </u>		8~		Jarrel	0		-	
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2	death certificate e attending physi d for use as the	/ledi	IF FEMALE:			_	1)										
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7.	requires that the een signed by th hould be detache	by Ph	Part il. Other signi	ificant condition	ons contributing t	to death b	out not resu	ulting in th	ne underlying	g cause giv	en in Part	il.	23e. Did	tobacco	use cont	ribute to	the cause of death?
cords	equire en sig ould b												1 🗆	Yes 2	□No	3 □ Pro	obably 4 Unknown
ပ	law r nas be e 2 shi	Completed											24a. Was	psy		prior to c	opsy findings available ompletion of cause of
	r: The icate ha												1□ Yes	ormed? 2 X No		death? 1 Yes	2□ No
VItal	Physician: this certific ral director,) Be	25. Was case refe examiner? 1 ☐ Yes 2र्	rred to medical No	Hospital: 1	I ☐ inpatie	ont 2□	ER/Outp	atient 3∐ I	Oth	or.		h (Check only			(0	
0	ding Physician: The lav n. After this certificate has funeral director, page 2	n: To	27. Manner of Dea	ath	28a. D	ate of Inju	ıry	28b. Tin	ne of	28c. Inju		Nursing Ho	me 5 Resi 28d. Describe				ny)
101	endin sath. or: Aft he fur	atio	1 Natural 2 Accident	5 ☐ Pendin investig	gation	wonth, De	ly reary	inje	M		Yes 2	□No					
DIVISION	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could r determ	200. F	lace of inj uilding, el	jury - At ho tc. <i>(Specif</i>	me, farm	, street, fact	ory, office			28f. Location (City or To			er or Ru	ral Route Number,
_	spital		29a. Certifier		g Physician: To												
	the Ho	Medical	(Check only one)			ne basis o manner st		tion and/					red at the time				
		Σ	29b. Signature and	d title of certifie	19			m		29c. Licens	se number				_		n, Day, Year)
	f.G.		30. Name and add	tress of person	who completed	cause of c	death (iton			<i>y</i> -	, , 7	9 -1		Jl	ine i	8, 2	UU3
(2		Show	LA.	tashni	821	N. E	utaw	st. S	Suite	308	Balt	imore,	MD 2	2120	1	
	Sta		31. Date filed (Mo	nth, Day, Year)	8 2000 3	2. Regist	rar's Signa	ture	back	1							
	Registr	ar		JUN U	0 2000	MAN		10.	7	47.1							

		•	For State Registrar		State of Ma	aryian	•	artment of F rtificate of I		and Mei		iene eg. No. 🥎 🎧	000	10026
	Physicia	an	1. Decedent's Name		•				-		Date of Death	1	Year	3. Time of Death
	/Medic	al	Shirley 4a. Facility Name (If	Ann Bed				4b. City, Town, o	r Location of		rune 3,		y of Death	5:37 Ам
e Serie	Examin	er	231 Corne		,			Woodsbor		Deall		Frede		
	Funeral		5. Social Security Nu	1	ex 7. Age		ast birthday)	if Under 1 Year Months Days	If Under 2 Hours	24 Hrs. 8. Min.	Date of Birth (Month, Day, b) 13,	Year)	9. Birthp	lace (State or Foreign try)
	Director	ŀ	268-26-92 Usual Residence of D	256		79	Yrs.			F.€	20 13,	1930	Ohio	
	ırylanc show	_	10a. State	10b. County		10c. City	, Town or Lo	cation					10	Od. Inside City Limits
	he Ma 28a-f s	Director		Frederic	k	Wood	lsboro	1.07 TO 1			Tax	0.00	10/1	1 ☐ Yes 2 XNo
	3a or 3	i Dir	10e. Street and Number 231 Corne					10f. Zip Code 21798				0g. Citizen of J SA	what Coun	try?
	ems 2	Funeral	11. Marital Status		12. Was Decedent I	Ever in U.S	S. 13. V	Vas Decedent of H	lispanic Orig	gin? (Specify		14. Ra	ice - America	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Evanting rough by notified at	by Ft	1 ☐ Never Marrie 3 ☐ Widowed 4		1 ⊟Yes 2 📉 În În În În În În În În În În În În În	No		l □Yes 2 🔯 No	Specify:	1 40110 1 1101	ari oto.)		^{fy:} Whit	
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Maryland	2 should and Mer is marke raumatic		19a. Informant's Nar	.' '				g Address (Street						Code)
e, N	s 1 and 2 of Health a item 27 is other trai		April Bus		ugnter	20h BI		cition (Name of		WOOGS!		20c. Location		wn Stato
Baltimore,	permit. Pages 1 and Department of Heal Important: If Item 2 any Injury or other any Injury or other Duce.		1 ☐ Burial 2 ☐		Removal from State			sition (Name of natory or other place urney Cre						
altii	permit. F Departm Importar any Injur	1	21. Signature of Fun			1		Name and Addre		-				
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					lications that caused one cause on each lin	the death	. Do not ente	er the mode of dyir	ng, such as o	cardiac or re	espiratory arre	est,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (F disease or condition resulting in death)	iriai 🕝	a. Head and			ær						
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68760,	tificate be executed g physician and as the burial-transit	edical			d									
			IF FEMALE:	- 1										
Вох	eath certific attending p for use as t	cian/	23b. Was decedent printhe past 12 m 1 Yes 2	Diegnani i	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 🗌 Fetal	death 3	Ectopic pregnanc Other (specify)	у				ate of delive Ionth	Day Year
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S, F	ires tha signed	by P	Part II. Other signific	eant conditions co	ontributing to death bu	ut not resu	Iting in the un	nderlying cause give	en in Part I.					ne cause of death?
Vital Records,	w requir s been s should					<u> </u>								ably 4 💢 Unknown
Rec	he law e has I ge 2 s	Completed									24a. Was ar autopsy perform	v l	. Were autoportion to condeath?	psy findings available appletion of cause of
ta	hysician; The la	Be Co	25. Was case referre	ed to medical					26. Place	of Death (C	perform 1 □ Yes 2 Check only one		1 ☐ Yes	2 □No
<u>></u>	hysici his ce il direc	은 일	examiner? 1 ∐ Yes 2 [X]N	fo	Hospital: 1 ☐ Inpatie	nt 2 🗆 8	ER/Outpatien	t 3□DOA Oth	0.81		5X Reside	,	ther (Specify	y)
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/isic	Attender death ector: by the	ficat	2 Accident 3 Suicide	investigation 6 ☐ Could not be determined	28e. Place of Inju	ıry - At hor	me, farm, stre		Yes 2 □N		Location (Str	reet and Num	nber or Rura	l Route Number,
ó	ours after eral Dire	Certification:	4 Homicide	dotorminod	building, etc	c. (Specify	")			- 1	City or Town	, State)		
	To the Hospital or Attending Physician: The Funeral Director. After this certification of the Funeral Director. After this certification place of the Funeral director.	edical ((Check only 2	Certifying Phy	/sician: To the best of iner: On the basis of	f examinat	vledge, death ion and/or inv	occurred at the til	me, date and pinion, deat	d place, and th occurred	d due to the ca at the time, da	ause(s) and rate and place	manner as s	tated. the cause(s)
	To the Hos within 24 ho To the Fun completely	Med	29b. Signature and tit	tle of dertifier	and manner sta	ited.		29c. Licens	e number		29	9d. Date sign	ed (Month,	Day, Year)
	- > - 0		1	MA		•		D3563	5		J	Tune 3,	, 2009	
	3)02		30. Name and address						1	ME O	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\			
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	Registra	r	31. Date filed (Month	JUN U'8 2	009 Bus	- 9	A 16	n. N. 1						

Dana Andrew Ba		nan 1- For State	Sta	ate of Maryl		artment o		and	Menta	al Hyg			20	0 9	1992
Physicia		Registrar 1. Decedent's Nam	ne (First, Middle	a.Last)			Death			2.	. Date of De	Reg. No. ath	E W	3. Time	of Death
Medical Examir				Bachman							Month June 2, 2	Day 2009	Year	1700) hrs
(4a. Facility Name (if not institution	n, give street and n			4b. City, Tow		ocation of	Death			. County of De	ath	
,				orill State Park			Frederic				 		rederick	2: 45 - 12 76	Nata
Funeral		5. Social Security I		6. Sex	7. Age (In yrs.		If Under 1 Months	Year Days	If Under Hours	24Hrs. Min.				eign	
Director		279–50–		1 X M 2 F		50 Yr		,-			Oct 1	8,	1958	Country)O	110
any	-	Usual Residence of 10a. State	f Decedent 10b. County		10c. Cit	y, Town or Loca	tion							10d. Ins	ide City Limits
10 W 21		MD	Freder	rick		derick								1 XY	res 2 No
nylan ta-f st	Ę.	10e. Street and Nu			1-20		10f. Zip Co	ode				10g. Citi	zen of What C	ountry?	
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director	359 Cat	octin A	venue			2170	1				USA			
with ms 23.	era	11. Marital Status	TV.		ecedent Ever in		as Decedent					No-	14. Race - Am White, etc		n, Black,
· death	Funeral	1 Never Marr	ied 2 X Ma	1 X Yes	Forces?					CONOTO	ioun, oto.)			White	
s after ral", inter	à	3 Widowed		orced If Yes, Give Ye or Dates:		2 1	Yes 2 X			nd of wo	rk done	16h	Specify: Kind of Busines		
2 hour	ted	Elementary/Sec		ify only highest gra	(1-4 or 5+)	during r	nost of working	ng life. [DO NOT u	se retire	d)	100.	Taria or Edonio	,o, madon y	
36 hin 72 e. than	ple	Ziomoniai yrooo	ondany (0 12)	1	(, , , , ,	Powde	red Me	dia	Tech	mici	ian	Bi	lotech		
5-0036 led within 7 Hygiene. I other than	Completed	17. Father's Name	(First, Middle,	Last)				18	8.Mother's	Name (I	First, M iddle	, Maiden	Surname)		
2121 2121 201d be fill 1 Mental F marked ic event, t	Be			Bachman							Eller				
21 thould thould nd Me is ma atic er	٤	19a. Informant's N		nip (Type, Print) man/wife									ity or Town, St MD 217		de)
MD 2 sho salth and 2 she and 27 is em 27 is raumat		20a. Method of Dis		mail, wile). Place of Dispo					Date		Location - City		tate
Ore				3 Removal	from State	crematory or o	ther place)		·	. 06	Inc Inc	, , ,,,,,	oaidbac	ME	
altimore, mit. Pages la ppartment of He pportant: If ite		4 Donation 5	Other Sp		F T	nal Jou							odbine		
Ba Perm Depa Impo		75 1	L L	1.11-4	_ MO1	7E1 T	oing H	ome	Cren	natio	on ser	VICE	P.O.	BOX /	/84 MD 2102
Physician		23a. Part I. Enter t	he disease, or	complications that	caused the dea	th. Do not enter	the mode of	dying, s	uch as ca	rdiac or	respiratory	arrest, sh	lock, or heart	Ap ro	een Onset and
/Medical	1	Immediate Cause	nly one cause (Final disease	Introoral C	Sunshot Wo	und									Death
xaminer		or condition result			a consequence	of):									
	<u>.</u>	Sequentially list of		b. Due to (or as	a consequence	of):									
	Ē	(Disease or injury	enying Couse	C											
ed nsit	Examine	events resulting in		Due to (or as	a consequence	of):									
iO, e be executed ysician and burial - transit	edical	UNPENDE)	AMENDED)					<u> </u>					
60, ate be hysici e buri		IF FEMALE:		23c, If yes	s, outcome of pre	egnancy		_			-	23	3d. Date of deli	very	
68760 certificate rding phy	an/I	23b. Was deceden past 12 month		le 1 Live	birth	2 F	etal death	3	Ectopic	pregnan	су		Month	Day	Year
Box (e death continued for use	Physician/M	1 Yes 2	No 9 Unk	nour	gnant at time of	death 5 (Other (Specify	y)				- 1			
ords, P.O. Box 6876 w requires that the death certificate sheen signed by the attending phy should be detached for use as the	Phy	Part II. Other sign	nificant condit		to death but no	t resulting in the	underlying c	ause gi	ven in Par	rt I.	23e. Di	d tobacco	o use contribut	e to the caus	se of death?
P.O. es that the igned by be detac	d by										1	Yes 2	✓ No 3	Probably 4	Unknown
rds, requir	Completed		-								24a. W	as an itopsy			ndings available on of cause of
Recol The law icate has	dmo										pe	erformed?	deat		2 No
II R	ပို	25. Was case refe	erred to medica				26	Place	of Death (Check o				1	
of Vital Records, g Physician: The law requir lifer this certificate has been s neral director, page 2 should t	Ö	examiner?	2 No	Hospital: 1	Inpatient 2	ER/Outpatie	nt 3 DO	A C	Other ₄	Nursing	Home 5	Resid	dence 6 🗸 C	ther: Scene	
ision of Vital Records, P.O. Box 6876(Attending Physician: The law requires that the death certificate ordeath. ector: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the b.	n: T	27. Manner of Dea		28a. Da	te of Injury hth, Day,Year) ID:	28b. Time o	· · ·		y at Work		28d. Descri Subject s		njury occurred		
ion ttendi death.	atio	1 Natural 2 Accident	5 Pend Inves	stigation Jun 2,	2009	FOUND: 1630 hrs		<u> </u>	es 2 🗸	No				-	
Division tal or Attendir rs after death. al Director: A	Certification:	3 🗸 Suicide		d not be	ace of Injury - Al			office bu	uilding, etc	- 1	or Tow	n. State)	and Number on St. Park		te Number, City
Dospital bours uneral		4 Homicide 29a. Certifier		10,000	y) Park/Red					- 171					(, IVID
# 4 F 5	Medical	(Chaole only	Medical Exa	nysician: To the b miner:On the basi	s of examination	euge, death occ n and/or investig	ation, in my o	ppinion,	death oc	curred at	the time, d	ate and p	lace, and due	to the cause	e(s)
To the within To the comple	Mec	29b Signature an		and manner	r stated.				e number				I. Date signed		
		/ 1 n.	Inla	4.0				O.C.N	И.E.			Ju	ne 3, 2009		
		30. Name and add	dress of person	who completed ca	ause of death (It										
8/2		Laron Lock		ssistant Medic	cal Examine	r 111 Per	n Street, I	Baltim	nore, M	D 2120	01				
	ate	31. Date filed (Mo.	nth JUN O	8 2009 ^{32.}	Registrar's Sign	ature A	barker	,							
Regist	ıralı			/		12.19	47 67		-						

DHMH 17 Rev 1/2001 OCME 2006

Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Denastment of Health and Marial Hydione		9300
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	sicia ledica amine	1
	cute	To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	

	1 - State Registrar 1 - December 1 - Decemb		Cei	rtificate of I	Death	2. Date of D	Reg. No.	2009	3. Time of) 2 Death
ian	1. Decedent's Name (First, Middle, Last) YVONNE E. BRAXTON					Month	Day	2009 ^{Year}	1657	Death
cal ner	4a. Facility Name (If not institution, give street and nu			4b. City, Town, or	Location of I			County of Death		
ier	SOUTHERN MARYLAND HOSPI	· ·	ΓER	CLINT			PRI	NCE GEO	RGE'S	
	Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of E Min. (Month, I	Birth Day, Year)	9. Birth Cou	place (State o	
	213-56-1551 1□M 2只F Usual Residence of Decedent	60	Yrs.			April4	,1949) New	York,	N.
	10a. State 10b. County	10c. City	y, Town or Lo	cation					10d. Inside Ci	ty Lim
ctor	Maryland Prince Georges	D	istric	t Heights	1				1 ⊠Yes	2 🗆 1
Director	10e. Street and Number			10f. Zip Code			10g. Citi	zen of What Cou	intry?	
	1580 Addison Rd. South			20747		0.00 11. 11. 11.		Jnited S		
Funeral	11. Marital Status 1 ▼ Never Married 2 Married 1 ▼ Yes		S. 13. \	ras Decedent of H f Yes, specify Cuba	iispanic Origii an, Mexican, f	n? (Specify Yes or I Puerto Rican, etc.)	NO-	 Race - Amer Black, White 		
þ	3 ☐ Widowed 4 ☐ Divorced Year or D	ive	'	1 □Yes 2 🙀 No	Specify:			Specify: B1	ack	
Completed	15. Decedent's Education (Specify only highest grade completed)		16a. Dece	dent's Usual Occup	ation	of working	16b. Ki	nd of Business/li	ndustry	
Jg I	Elementary/Secondary (0-12) College (life. I	DO NOT use retired	d)		Go	overnmen	ıt	
	12 17. Father's Name (First, Middle, Last)		Cont	racting	_	LIST s Name (First, Midd	le. Maiden	Surname)		
To Be	Harvey Braxton					ian Hende		,		
F .	19a. Informant's Name/Relationship (Type. Print)		19b. Mailir	ng Address (Street	and Number	or Rural Route Nun	nber, City o	r Town, State, Z	ip Code)	
	Nikia Y. Braxton / Dau	ghter	1580	Addison	Rd. So	outh Dist	rict E	Heights,	Md. 2	074
	20a. Method of Disposition 1	20b. P	lace of Dispo emetery, cren	sition (Name of natory or other place	ce)	Date	20c. Lo	cation - City or T	Town, State	
	4 □ Donation 5 □ Other (Specify)	Ha		Memorial		/8/2009		andover,		
	21. Signature of Funeral Service Licensee	A	22	Name and Addre Alexande	ss of Facility	pe PA.	4	11. WJ	2074	7
	23a. Pa. 1. Enter the disease, or omplications that shock, or heart failure. List only one cause in climmediate Cause (Final disease or condition resulting in death)	each fine.	n. Do not ent		ng, such as ca	ardiac or respiratory			Approximat Interval Bet Onset and I	tween Death
dical Examiner	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events	(or as a consequence of the cons	uence of):							
Physician/Med	in the past 12 months?	utcome of pregna birth 2□Feta gnant at time of c nown	Ideath 3[Ectopic pregnanc Other (specify)	y	-	-	23d. Date of deli Month		Year
þ	Part II. Other significant conditions contributing to d	death but not resi	ulting in the u	nderlying cause giv	en in Part I.		d tobacco u ∐Yes 2[use contribute to ☐ No 3 ☐ Pro	the cause of cobably 4 🕱	
Completed						pe	topsy rformed?	prior to death?	topsy findings completion of c	availa cause
Be C	25. Was case referred to medical	·			26. Place o	of Death (Check onl	y one)	ILlifes	2 (4) 100	
은	27. Manner of Death 28a. Date	Inpatient 2 of Injury onth, Day, Year)	ER/Outpatier 28b. Time of Injury	f 28c. Injur Wor	4 □ Nurs ry at k?	sing Home 5 Re			cify)	
Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place	e of Injury - At ho ling, etc. <i>(Specif</i>	ome, farm, str y)	M 1 □	Yes 2□No	28f. Location	(Street an Town, State	nd Number or Ru	ıral Route Nun	nber,
O.	29a. Certifier (Check only one) 1 Certifying Physician: To the 2 Medical Examiner: On the and man	basis of examina	ition and/or in	vestigation, in my	opinion, death	n occurred at the tim	ne, date and	d place, and due	to the cause(s	
				29c. Licens	e number		29d. Da	te signed (Monti	h, Day, Year)	
Medical Ce	29b. Signature and title of certifier									
		_ M.D.		D	3446	5		5.31.0	9	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	iryland / [tment of F ificate of I			giene Reg. No. 2 () ()	9 19929
			Decedent's Name (First, Middle, Last	st)					2. Date of De Month		3. Time of Death
П	Physicia /Medic		Eric Allen Coop	er					June	07 200	
	Examin		4a. Facility Name (If not institution, giv	e street and number)		4	4b. City, Town, or	r Location of Death		4c. County of E	
4			51 Union Street 5. Social Security Number 6. S	7 Ago	(In yrs, last bir	rthday)	Westm If Under 1 Year	inster If Under 24 Hrs.	8. Date of Bir	Carro	11 Birthplace (State or Foreign
	Funeral Director			M 2□F	44		Months Days	Hours Min.	(Month, Da	19, Year)	Country) MD
	TO		Usual Residence of Decedent						- Carr	72 1705	
	arylan show	_	10a. State 10b. County		10c. City, Tow						10d. Inside City Limits 1 □¥ es 2 □ No
	he Ma	Director	MD Carrol	1	We	estmi	nster			10g. Citizen of Wha	
	with t	Dir	10e. Street and Number 51 Union Street				10f. Zip Code 211	57		USA	
	death	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Wa		lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No		American Indian,
39	2 should be filed within 72 hours after death with the Maryland and Member Hygene. and Member Hygene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Modical Experiment reast by routilised at	by Fur	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 X N If Yes, Give Year or Dates:	О		'es, specify Cuba ⊒Yes 2. ∏ ogo	Specify:	o Hican, etc.)	Specify:	White, etc. Black
Š	2 hou atura ical E		15. Decedent's Ed	l Jucation	16a	. Deceder	nt's Usual Occup	ation during most of work	kina	16b. Kind of Busin	ess/Industry
21215-0036	ithin 7 ne. ian "n	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. DC	NOT use retired	during most of world)	king		
2	led wi Hygier her th		12				N/A	19 Methor's Nam	o (First Middle	Disa , Maiden Surname)	ртеа
_	_ 0 9	Be (17. Father's Name (First, Middle, Last) Charles Junior C							e Brown	
Maryland	should be f and Mental s marked o's umatic eve	ျှ	19a. Informant's Name/Relationship (198	o. Mailing	Address (Street			er, City or Town, Sta	te, Zip Code)
S S	nd 2 salth an 27 ls 27 ls r trau		Yvonne Cooper/Mot				ion Str		minster		
e,	es 1 a of Head of Head items		20a. Method of Disposition				tion (Name of tory or other place		Date	20c. Location - City	y or Town, State
altimore,	Page ment ant: If ury or		1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			-	hapel C		1/2009	Westmins	ter, MD
Balt	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evonce.		21. Signature of Funeral Service Licer	Sol)						Chapel, P. minster,	
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do						Approximate Interval Between
-	Physician	7	Immediate Cause (Final disease or condition			lese	to Ru	Hurod o	lia 1 - 5	Shuut	Onset and Death
-	/Medical Examiner		resulting in death)		a consequence						
		ē.	Secuentially list conditions, if any, leading to immediate	b. Due to (or as a	a consequence	oi):					
	cuted id ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	C							
0	ficate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a	a consequence	of):					
68760,	cate b ohysic the bu	edical		_d				-			
9 X	eath certific attending p for use as		IF FEMALE:	23c, If yes, outcome	of pregnancy					23d. Date o	f delivery
Вох	death e atter d for u	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at			Ectopic pregnand Other <i>(specify)</i> _	у		Month	
<u>о</u>	at the de by the tached	hys	9 Unknown	9 🗌 Unknown							
S,	es tha igned be de	þ	Part II. Other significant conditions	contributing to death bu	it not resulting i	in the und	lerlying cause giv	ren in Part I.			ite to the cause of death? ☐ Probably 4 ☐ Hrown
Division of Vital Records,	w requir been s should	Completed							24a. Was		re autopsy findings available
Re	he law e has ge 2 s	ldm							auto	psy prio ormed? dea	r to completion of cause of th?
ā	iclan: The certificate hirector, page		25. Was case referred to medical					26. Place of Dea	1 □ Yes		Yes 2□No
<u> </u>	Physiclan: this certific al director,	To Be	examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	nt 2 ER/O	utpatient	3 □ DOA Oth	or.	. /	idence 6 Other	(Specify)
0	ding Ph h. After th funeral	J:L	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	ry 28b.	Time of Injury	28c. Inju Wor	ry at k?	28d. Describe	how injury occurred	shunt
Sio	tendij eath. or: A the fu	catic	2 Accident investigation 3 □ Suicide 6 □ Could not b	0	9 1 13	-30	M 1□	iYes 2. ZNo	ersungu		u dialysis
Ž	or At after d Direct in by	Certification:	4 ☐ Homicide determined	building, etc	(Specify)	arm, stree	et, factory, office		City or To	wn, State)	or Rural Route Number,
	spital ours a neral filled		29a. Certifier 1 ☐ Certifying Pl	nysician: To the best of	of my knowledg	e, death	occurred at the ti	ime, date and place	5 (Union	e cause(s) and mann	13:01
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	Medical		miner: On the basis of and manner sta	examination a						
	Vithir Vithir Comp	Me	29b. Signature and title of certifier				29c. Licens	se number		29d. Date signed (/	
	WIL		MILITIVI				1000	51924		June 08.	2067
	4		30. Name and address of person who Herbert D. Hen	completed cause of de	eath (Item 23a)	(Type, Pr	Man	healer	RIW	lauchy dy	MO 2110,5
	Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	,	,	1.1.		-6.7.6	-
	Registr	ar	HIM O O	2000 2		9 A	an del				

09-04728 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 19930 Vayan Lajon Cann, Sr. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Month Day June 14, 2009 1117 hrs Medical Examiner Vayan Lajon Cann Sr. 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Kent 102 Lincoln Drive Chestertown If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Country) MD Director 214-70-7329 1 M 2 F 52 05/28/1957 Yrs Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location MD Yes 2 No Kent Chestertown death with the Maryland Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code 102 Lincoln Drive 21620 IISA Funeral 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 Married 1 Never Married Black Yes If Yes, Give Year Yes 2 No specify: Widowed Divorced Specify. \$ 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Mayflower Moving Elementary/Secondary (0-12) College (1-4 or 5+) within 7 and Storage Truck Driver 10th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marion Valentino Cann Clara Rosetta Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) QW Gwendolyn Cann/Wife 766 Seawall Rd. Baltimore, MD 21221
Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Direct Crematory or other place) 2 Cremation 3 Removal from State 06/23/09 Dover, DE. Other Specify 22. Name and Address of Facility Bennie Smith Funeral Home 1. Signature of Fun al Service Licensee Road 298 Chestertown, MD 21620 the Time Enter the disease, or complications that based the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): that the death certificate be executed Physician/Medical AMENDED 23a, PII, 27, permE, g896 10/28/09 TT X UNPENDED Box 68760 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? o à Chronic alcoholism Probably 4 V Unknown No 3 Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has death? performed? 1 🗸 Yes 2 No certificate ✓ Yes 2 26.Place of Death (Check only one) Fo the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be Hospital: Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 Nursing Home 5 1 Yes 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury Certification: 1 X Natural Pending Yes 2 No the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. DOME June 15, 2009 30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registrar . Registrar's Sign

alle

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legit Amend item#5 cecilCounty Health Dept-VD State of Maryland / Department of Health and Mental Hygiene	ole.
1 - For State Registrar Certificate of Death Reg. No.)	10031
1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day	3. Time of Death
Physician Gwendel Hoover Collette June 6, 200	9 2:44 a M
Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	
Union Hospital of Cecil County Elkton 5 Social Sequent Number 6 Sex 7 Ang (In vis. last hirthday) If Under 1 Year If Under 24 Hrs. 8, Date of Birth	Cecil
Funeral S. 3210 - 22 - 1962 U. 35 N 2015 Months Days Hours Min. (Month, Day, Year)	9. Birthplace (State or Foreign Country) Maryland
Director	Maryranu
	10d. Inside City Limits
The state of the s	1 ☐ Yes 2√ No
Maryland Cecil Elkton Compared to the control of	/hat Country?
114 Woods Way 21921	e - American Indian,
11. Marital Status 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-Indian, etc.) 14. Racc Higher Specify Cuban, Mexican, Puerto Rican, etc.) 14. Racc Higher Specify Cuban, Mexican, Puerto Rican, etc.)	k, White, etc.
9	White
10a. State 10b. County 10c. City, Town or Location Total Part 10b. Maryland 10c. City, Town or Location	usiness/Industry os 66 Station
College (1-4or 5+) College (1-4or 5+) College	lle, Maryland
Seven Years Owner/Operator Perryv	
Moses Hunter Taft Collette 17. Father's Name (First, Middle, Last) Moses Hunter Taft Collette Ruth Naomi Lo	
Process of the proces	State, Zip Code)
E ਨੂੰ ਰਿਸ਼ਰੀ Dorothy Collette (wife) 114 Woods Way, Elkton, Maryland 2192	21
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	City or Town, State
15 Burial 2 Cremation 3 Removal from State Harford Memorial 06/10/09 Aberdeen	, Maryland
10b. County 10c. City, Town or Location 10d. City 10d. Cit	ome, P.A.
TELL VIII C. Hall VI and 21 July 18 19 19 19 19 19 19 19 19 19 19 19 19 19	3-0766
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
Physician / Immediate Cause (Final disease or condition resulting in death) Medical	UNKnown
Examiner MOSA Society	Unknown.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	
9+1 VA 15 p E Cause (Disease or injury that initiated events c	
fificate be gaphysici as the bu	
S S S S S S S S S S S S S S S S S S S	te of delivery
23b. Was decedent pregnant in the past 12 months? Continue Co	onth Day Year
O of the state of	
Column C	tribute to the cause of death?
Sping 50 Chronic Kidney Discase. 1 Yes 2 No	3 ☐ Probably 4 ☐ Onknown
24a. Was an autopsy	Were autopsy findings available prior to completion of cause of
performed la la la la la la la la la la la la la	death? 1 □ Yes 2 □ No
25. Was case referred to medical examiner?	
Hospital: 1 ⊈npatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other: 4 □ Nursing Home	
C to the part of Death 28a. Date of Injury 28b. Time of Linjury at Work? 28d. Describe how injury occur work? 28d. Describe how injury occur work? 1 Yes 2 No	100
2 Accident investigation inves	ber or Rural Route Number,
27. Manger of Death 27. Manger of Death 28. Death of the property of the pro	
9 3 0 = 1 = 1 29a Certifier 1 T Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and m	anner as stated. , and due to the cause(s)
29a. Certifier 29a. C	ed (Month, Day, Year)
290.8 Signature around of certifier 290.8 Signature around 290.23322 6.8	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	r ·
S. S. S. Clader M.D. 126 A. F. High St. Elban MD 21921	
3,0 3400000 , 100000	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year 15.08 PM Edwar nn JUne /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1**X** M 2 □ F Days Director 229-58-9644 64 1/25/1945 Balty, VA Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at Director 1 X Yes 2 No Maryland Prince George's Temple Hills 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. or items 23a or must be 5311 Keppler Road Funeral 20748 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ If Yes, Give Year or Dates: Specify: Specify: BLack 3 Widowed 4 Noivorced "natural" Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Auditor / Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be marked Forrest Coates မ Catherine Freeman and I 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a Juma Coates / Son other t 3800 Light Arms Place Waldorf, Maryland 20602 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5 1 XBurial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. 4 Donation 5 Other (Specify) Maryland Veterans Cheltenham, Maryland 6/12/2009 e of Funeral Service Lice 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlbor Pike Forestville, maryland 20747 Part Effer the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OPSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death curtificate be executed Due to (or as a consequence of) Box 68760, Ittending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by director, page 2 should be 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops 2 No 1 TYes 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 1 Inpatient Other: 1 ☐ Yes 2 X No မ 2 ER/Outpatient 3 DOA 4 🗆 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) Injury eral Director: A 1 🗌 Yes 2 🗌 No after death 3 Suicide Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a

To the Funeral D

completely filled i 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) RPS-000 kure 3, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 ldstei 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year CHARLES LINBURGH CARMAN 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 24 Hrs 9. Birthplace (State or Foreign Country) Maryland **Funeral** al Security Number Date of Birth (Month, Day, Hours Days 1**X** M 2□ F Min 218-16-5999 Director 81 June 16, 1927 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Exar, insurmust be notified at Maryland Somerset Crisfield Director No Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 40 Maple Street 21817 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 Noworld Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 if Yes, Give Year or Dates: War II 1 ☐ Yes 2 🔀 No Specify. Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. Waterman Seafood is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John William Carman Alma Somers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) : If item 27 is or other tra 40 Maple Street - Crisfield, MD Norma Lee Carman (Wife) 21817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) Sunnyridge Memorial Park 6/11/09 Crisfield, MD 21. Signature of Fiberal Service Licenson Robert H. Bradshaw, 22. Name and Address of Facility Bradshaw & Sons 306 W. Main St. 21817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ANEMIA /Medical Due to (or as a consequence of): Examiner BUEFE Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 40 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes 2 1√1√0 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical (Check only

State

31. Date filed (Mon

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 E

and manner stated.

29d. Date signed (Month, Day, Year)

registrar's Signatur

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jun 12, 2009 **Physician** Maud Margaretta Dodd 11:15PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Golden Living Center Cumberland Allegany 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Aug 20, Birthplace (State or Foreign Country) **Funeral** Year) 1 □ M 2 □ Ę Months Days Hours Director 214-05-7137 96 1912 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f sho MD Allegany Cumberland Director 1 □¥es 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 512 Winifred Road 21502 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 233 any injury or other traumatic event, the Westicel Examble any jurge. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 □ Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 □ No Specify. Specify: 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Montgomery Ward 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) George E. Robertson Maud Margaretta Harding ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Conway niece 315 Homer Street MD 21502 Cumberland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Desemation 3 Removal from State Rose Hill Cemetery 6/16/2009 4 ☐ Donation 5 ☐ Other (Specify) Cumberland MD 21. Signature of Funeral Service 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a Peri 1. Ent of the disea e, or shock, or heart failure List complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause of each line. Approximate Interval Between Onset and Death Immediate Couse (Final disease or condition resulting in year h) Silvan **Physician** ovonou /Medical Due to (or as a consequenc of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the conjugation of the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be execute burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 5 ☐ Other (specify) ☐Yes 2☐No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed cate has by page 2 s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe certificate 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1□Yes 2€No Hospital: Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 4 ☐ Pursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 1 □Yes 2 □No 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0033280 June 13, 2005

State Registrar

31. Date filed (Month, Day,

SUNL GUPTA, M.D. 623 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KEM

AVE. CUMBERLAND, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State RegistraMEND#4a,4lopenMD,6/5/09,BMW,MoCo Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day ABRAVI ETSE 9:30P M 30 2009 May 4b. City, Town, or Location of Death Burtonsville 4c. County of Death 4a. Facility Name (If not institution, give street and number)
HOLY Cross Sanctuary
HOLY Cross Nursing Montgomery 9. Birthplace (State or Foreign Country) TOGO W. Africia If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) Hours Days 1 □ M 2 🛛 F W. 38 26,1970 213-71-3024 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location 1 Yes 2 No MD Montgomery Gaithersburg 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 447 20878 West Africia W. Diamond Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sam's Club Cashier 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Kekeli Etse Nabure Kouqbenya 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Patrick Allala-Cousin PO Box 13824 Fairlawn, OH 44334 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Souls Cemetery 6/4/09 Germantown, MD 22. Name and Address of Facility Snowden Funeral Home, PA 21. Signature of Funeral Service Linnsee 246 N. Washington St Rockville, MD20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC BREAST CANCER Due to (or as a consequence of): Sequentially list conditions, it is yearly to include the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery dent pregnant 3 Ectopic pregnancy Year Month Day st 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) 2**X N**o g Unknown 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 🗖 No 1 ☐ Yes 2 🛣 No 25. Was case referred to medical examiner? ly one) H 1 ☐ Yes 2 ☑ No esidence 6 Other (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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marked other

permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is n any Injury or other traun once.

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72 hours after

Saltimore, Maryland 21215-0036

Box 68760

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Division of Vital Records,

Director

Funeral

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Completed

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innertal Innertal director, page 2 should be detached for use as the buriat-transit Certification: To

Physician/Medical \$ Completed Be (

IF FEMALE:
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Part II. Other s

27. Manner of Death

Natural

3 Suicide

2 Accident

4 Homicide

				26. Place of Dea	th (Check on
				Other: 4 Nursing H	
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28a. Date of Injury (Month, Day, Year) 5 Pending investigation 6 ☐ Could not be

and manner stated.

28c. Injury at Work? М 1 ☐ Yes 2 ☐ No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the death occurred at the time, date and place, and due to the cause(s) a

29b. Signature and title of certifier

29c. License number D28595

June 3, 2009

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 2835 Smith Ave Baltimore, MD 21209 Tasneem, Lakhami,

State Registrar

Medical

31. Date filed (Month, Day, Year) JUN 04



To the within 2

			State of Maryland / I	•	ment of H icate of L			ene	9 19936
	Physicia		1. Decedent's Name (First, Middle, Last)				2. Date of Death Month May 31		3. Time of Death
We did	/Medic	al	Rose Gressette 4a. Facility Name (If not institution, give street and number)	4b.	. Citv. Town, or	Location of Death	may 31	4c. County of I	20:28 PM
?	Examin	er	Garrett County Hospital		_	akland		Garı	rett
	Funeral Director		5. Social Security Number 5. Social Security Number 6. Sex 1 M 2 X F 74		Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 08/09/1	Year)). Birthplace (State or Foreign Country) DC
	D		Usual Residence of Decedent 10c. City, Tow 10a. State 10b. County 10c. City, Tow	vn or Locatio	on				10d. Inside City Limits
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	r 28a	Director	10e. Street and Number	10	Of. Zip Code		10	g. Citizen of Wha	at Country?
	th with		706 E. Alder Street			1550			ted States
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:		Decedent of Hi s, specify Cuba Yes 2. X No	ispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black,	American Indian, White, etc. Black
Baltimore, Maryland 21215-0036	n 72 hour " natural ledical Ex	Completed t	15. Decedent's Education (Specify only highest grade completed)	(Give kind	s Usual Occup of work done of NOT use retired	during most of work		6b. Kind of Busir	ness/Industry
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bd	al Hyg	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, M	laiden Surname)	
ylaı	ould b Ments arked aric e	To E	Clarence Hartley				e Hartle		
Mar	d 2 sh th and 7 is m traum	1	19a. Informant's Name/Relationship (Type. Print) John H. Gressette/ Son	-		and Number or Rur Street N			
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m 0	Pages ient of nt: If i		1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Memo	orial	ry or other plac Ty Park	1 12	2009	Landove	er, Maryland
Balti	permit. Departm Importa any inju	. 3	21. Signiture of Furieral Service Licenses	22. Na	ame and Addres	ss of Facility St ing Rd. N	ewart Fu	neral lic ngton, I	ome, Inc.
2	Physician	20	23a. Part1 Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final	not enter th	ne mode of dyir	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
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ou C	ing After	ion:	Natural 5 ☐ Pending (Month, Day Year)	. Time of Injury	28c. Injui Woi M 1 □	ryat rk? Yes 2 ∐ No	28d. Describe ho	w injury occurred	ā.
Division	or Attending after death. Director: After in by the fune	Certification:	Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, building, etc. (Specify)				28f. Location (St City or Town	reet and Number n, State)	r or Rural Route Number,
_	• Hospital or Attendi 24 hours after death. • Funeral Director: A etely filled in by the f	Medical Co	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)						
	To the Hos within 24 ho To the Fun completely	Me	29b. Signature and title of certifier	~	29c. Licens	se number	2	9d. Date signed	(Month, Day, Year)
	- > - 0		Muhagorot a Krim	M) D2	26650		June 11	., 2009
	2.		30. Name and address of person who completed cause of death (Item 23a			Oakland	Marri an 1	21550	
	Sta	ate	Margaret (A). Kaiser MD 13079 Garr 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ett Hi	rgnway	oakland,	maryiand	21550	
	Regist		31. Date filed (Month, Day, Year) JUN 2 2 2009 June 1 32. Registrar's Signature	all					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month ^{Day} 2009 3:55 pM May 31, **Physician** Howell Gordon, Jr. James /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Takoma Park Washington Adventist Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year April 10, 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Days Min Months Washington, DC 1923 1X M 2 □ F Yrs 86 579-18-7406 Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is Medical Examinar transitions. 10c. City, Town or Location 10b. County 10a State X¥Yes 2 □ No Funeral Director Takoma Park Montgomery Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20912 7310 Piney Branch Road 12. Was Decedent Ever in U.S. Armed Forces? 1 □ 36 es 2 □ No If Yes, Give Year or Dates: 1943-45 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White 1 ∏Yes 2XXNo Specify Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Telecommunications Engineer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Winifred E. Curtiss James Howell Gordon 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 7310 Piney Branch Road, Takoma Park, MD 20912 Sue M. Gordon/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition June 4, 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 2009 22 Name and Address of Facility ins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd. W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death Part 1. Inter the disease, or complications that caused the death. Do not enterathe mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or es a consequence of): Examiner nous Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? Pregnant at time of death 5 Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached to 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 X No 2 🗆 No 1 ☐ Yes 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔼 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 1 Matural the Hospital or Attending I thin 24 hours after death. Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of ပ္ June 3, 2009 D07850 Ot 1 cause of death (Item 23a) (Type Print) 7610 Carroll Avenue, Takoma Park, MD 20912 30. Name and address of person who complete to H. L. Marter, MD

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** une Graziani /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore City The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign 5. Social Security Number Age (In yrs. last birthday) Days **Funeral** Months Washington D.C 1**X** M 2 □ F 2/11/1948 61 218-52-8195 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State show Examiner must be notified at 1 ☐ Yes 2 X No Director Columbia Md. Howard 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code or items 23a or USA 21045 9124 Flamepool Way Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 1X Yes 2 □ No 1968− If Yes, Give Year or Dates: 1971 Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education event, the Medical (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Alpaca Breeder Farm 4yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anne Relac Angelo Graziani ဂ္ injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9124 Flamepool Way Columbia ,Md. 21045 Katherine K. Graziani/wife Department of Health a Important: If item 27 is any injury or other trai 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Crematory Inc. 6/8/2009 Hanover, Md. 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 21. Signature of Funeral Service MOO845 4112 Old Columbia Pike Ellicott City, Md. 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition /Medical resulting in death) Due to (or a a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed as the burial-trar Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: nse ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 - Fetal death 3 Ectopic pregnancy Day for in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 2 No signed by the at Id be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> 2 No 3 □ Probably 4 □ Unknown 1 Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check only one) filled in by the funeral director, Be Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 No 1 🗌 Yes 1 Dinpatient 2 - ER/Outpatient 3 - DOA မ After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 2 Accident Injury М 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 29a. Certifier 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatur title of certifier apo RES 6-05-09 006 EG 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month)

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parke

legistrar's Signature

			Pleas	se Type or Pri						_	ible.	
		4	For State Registrar	State of M	laryland	•	rtment of F tificate of	Health and I Death		21	1119	19939
			1. Decedent's Name (First, Middle	, Last)		Oei	inicate of	Death	2. Date of Dear			3. Time of Death
	sicia		Margaret	<i>N</i>	1			Hull	Month O6	O I	Year 2009	20:44 PM
	edica mine		4a. Facility Name (If not institution	, give street and number	r)		4b. City, Town, o	or Location of Death		4c. Count	y of Death	
			University of A		_		Baltin				NONE	
Fune			5. Social Security Number 107–38–2864	6. Sex 7. A	ge (In yrs. la 60	ast birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day SEPTEMBER	Year)	9. Birth	place (State or Foreign htry) IEW YORK
Direct	tor	+	Usual Residence of Decedent		- 00				MA HAIDIA	10,1740		ILW TOTAL
ryland	3	_	10a. State 10b. County		10c. City	, Town or Lo	cation				1	Od. Inside City Limits
ne Ma		9		ARUNDEL				VERNA PAR		0.000		1 ☐ Yes 2 No
d 21215-UU36 filed within 72 hours after death with the Maryland Hygiene. Hysther than "natural", or items 23a or 28a-f show		Funeral Director	10e. Street and Number 285 MICHENER CO	IIDT FACT			10f. Zip Code	21146		0g. Citizen of	D STA	
Jeath	No.	Jera	11. Marital Status	12. Was Decedent	t Ever in U.S	S. 13. V	Was Decedent of I	Hispanic Origin? (Si	pecify Yes or No-	14. Ra	ace - Ameri	can Indian,
or iter	1		1 ☐ Never Married 2 ☐ Marri	Armed Forces ied 1 □Yes 2 If Yes, Give	?]No		fYes, specify Cub I□Yes 2 X INo	san, Mexican, Puerto Specify:	o Rican, etc.)		ack, White,	_
Z15-UU36 hin 72 hours aff e. an "natural", or		d by	3 Widowed 4 No Divorced	Year or Dates:	:						fy:WHL']	
157 n 72 h		ete	15. Decedent (Specify only highes	st grade completed)		(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of wor	king	16b. Kind of I	Business/In	dustry
Z1Z Z1ZZ d withii giene.		Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		URSING E	•			EDUC	CATION
other		Be C	17. Father's Name (First, Middle,	Last)				18. Mother's Nam	ne (First, Middle,	Maiden Surna	me)	
Maryland d 2 should be file lth and Mental H 27 is marked oth		0	ROBERT F. HULL					GERTRU	DE E. BI	ECKMAN		
baltimore, Maryland 2 Permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important; If Item 27 is marked other than high oven her transmite event			19a. Informant's Name/Relationsh				•	t and Number or Ru				
e, lond 1 and Health Part 27		-	ROBERT M. HULL/ 20a. Method of Disposition	BROTHER	20h P		I WOODLA sition (Name of	ND DRIVE,	Date	20c. Location		
Saltimore, Dermit. Pages 1 au Department of Hec mportant: If item	5		1 Burial 2 X Cremation		● CHE	SAPEAK	E CREMAT	TON JUNE	4.			
nit. Partme	- di	-	4 Donation 5 Other (Sp. 21. Signature of Funeral Service)		CEN	22	. Name and Addre	ess of Facility FET	LOWS HI	T.FENRE	TN AN	E, MARYLAND ID NEWNAM
Deg E	9		Mull Ed.		00672	CR RO	EMATION AD. ANNA	AND FÚÑĒR POLIS, MA	RAL CARE. RYLAND 2	P.A.,	814	BESTGATE
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each	ed the death							Approximate Interval Between
Physici	an	İ	Immediate Cause (Final disease or condition		1.	teun Ov	aan fail	Ure.				Onset and Death 2 days
/Medic			resulting in death)	Due to (or a	s a consequ	uence of):	garr son	0. 0				
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rted		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			,						1 day
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i / bU ate be e nysiciar ne buris		<u>a</u>		d. Th	orauc	aortu	c queury	smal dis	section			2 months
On Of VITAL RECORDS, P. O. BOX 68 / ding Physician: The law requires that the death certificate h. After this certificate has been signed by the attending physfuneral director, name 2 should be detached for use as the		Physician/Medic	IF FEMALE:									
GOX Bath cer attendir for use		lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	2 🗌 Fetal	death 3	Ectopic pregnan				ate of delive	very Day Year
the de		ysic	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	4 ☐ Pregnant 9 ☐ Unknown		eath 5L	Other (specify)					
requires that the seen signed by the hould be detached	i		Part II. Other significant condition	ns contributing to death	but not resu	ulting in the ur	nderlying cause gi	iven in Part I.	23e. Did to	bacco use co	ntribute to	the cause of death?
rds quires an sign uld be		od by							1 □ Y	es 2 🗆 No	3☐ Pro	bably 4 Unknown
ecords law requires as been sign 2 should be		Completed							24a. Was a		. Were aut	opsy findings available
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OT VITAL Physician: 1 This certifica		ge	25. Was case referred to medical examiner?				l au		th (Check only or	ne)		
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INISION or Attending after death. Director: Afte		iica I	3 ☐ Suicide 6 ☐ Could r	not be 28e. Place of Ir	njury - At ho	me, farm, str	eet, factory, office		28f. Location (S	treet and Nur	nber or Rui	al Route Number,
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To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t complete lilled in by the funeral				ng Physician: To the bes Exeminer: On the basis								
the Ithin 24 the F		Medical	one) 29b. Signature and title of certifier	and manner s				ise number		29d. Date sign		
P P P S	3		29b. Signature and the of certifier	0	1D			16435-15		06 03		
てリ		-	30. Name and address of person	0	death (Item	1 23a) (Tvne				V4 05		
10			Yosef Jose	Greenspon;	22 5	outh G	reene Sh	ect, ant	more, il	ID 21	201	
	State	-	31. Date filed (Month, Day, Year)	33 Regis	trar's Signa	ture pa	, del		,			
Reg	jistra	r	JUN 05	ZUUY Chiller	a, p		well from					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2:32 Ам 2009 Emily Scott Houchen June 4, 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Hospital Prince George's Cheverly 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 🖾 F Washington, DC 577-34-2927 81 December 4, 1927 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 X No Maryland Prince George's Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5907 Baltic Street 20743 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2 X No 1 ☐ Never Married 2 ☑ Married If Yes, Give Year or Dates 1 ☐ Yes 2 🕱 No Specify. Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Data Entry Clerk New York Life Insurance Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Catherine Fuller Robert L. Scott 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Houchen / Husband 5907 Baltic Street, Capitol Heights, MD 20743 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 6/15/2009 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licens 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EMPHEJE disease or condition resulting in death) Due to (or as a consequence of): Bleeda Gosto entest Sequentially list conditions if any, leading to in reduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav Yea 5 ☐ Other (specify) 1 □Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be

Physician /Medical Examiner

certificate be executed

Box 68760,

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Records,

Division of Vital

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/Medical

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Completed

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ir than "natural", or items 23a or 28a-f show the Medical Exeminer must be notified at

than "natural", or

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien. Important: If item 27 is marked other thr any injury or other traumatic event, the once.

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Saltimore, Maryland 21215-0036

Examine and burial-trai attending physician the as use ō been signed by the should be detached has certificate this Certification:

Physician/Medical þ Completed Be မှ

After t

or Attending

within 24 hours arter users....

To the Funeral Director: After furthe the Hospital Medical 6

State Registrar 29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number 18997000 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

m. Above Na, MD, 6005 Landover Rd., Suite #3, Cheverly, MD 20785

1 🔀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

31. Date filed (Month, Day, Year) JUN 0 9 2009

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

32. Aegistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** JR. ROBERT HEMBY 2009 6:45 A HINE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner CHARLES 10641 ASHFORD CIRCLE WALDORF Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 ₩ M 2 □ F NORTH CAROLINA 241-52-5331 Director OCT. 28 1936 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, Ite Madical Extraigrate russ be posited at 1X Yes 2 □ No Director WALDORF MD CHARLES 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20603 USA Funeral 10641 ASHFORD CIRCLE 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc ☐Yes 2 f Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No BLACK Specify Specify: ģ 3 Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE TRUCK DRIVER 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LAURA HOPKINS ROBERT HEMBY SR. ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10641 ASHFORD CIRCLE WALDORF, MARYLAND 20603 19a. Informant's Name/Relationship (Type. Print) A. WILLIAMS/DAUGHTER Baltimore, Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Important: If it any injury or or 1 💢 Burial 2 □ Cremation 3 Removal from State LANDOVER, MARYLAND HARMONY CEMETERY 6/12/2009 4 Donation 5 Other (Specify) permit. 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-tra resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? certificate 2 ⊋No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 A Residence 6 ☐ Other (Specify) Certification: To this To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 □Yes 2 □No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) son who completed cause of death (Item 23a) (Type, Print) of pe ASHRAF MELLU MD 10 ST PATRICKS DRIVE # 408 WALDORF, MARYLAND 20603 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2009 1:01 P JUN 4 RUDOLPH HARRIS 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death NATIONAL NAVAL MEDICAL CENTER MONTGOMERY BETHESDA If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Days Hours 1 □ M 2 □ F Months 81 421-22-4164 ALABAMA APRIL 10 1928 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County X□Yes 2□No PRINCE GEORGE'S BRANDYWINE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20613 13106 CURRANO COURT 13. Was Decedent of Hispanic Origin? (Specify Yes or No-F. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Ves 2 No AIRF 14. Race - American Indian, Black, White, etc. [™]2□No AIRFOR¢E 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify BLACK Specify. 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 4yrs Elementary/Secondary (0-12) GOVERNMENT SUPPLY TECH. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ELLA ANDERSON HARRIS JOHN. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13106 CURRANO COURT BRANDYWINE, MARYLAND 20613 KENNETH R. HARRIS/SON 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 7/15/2009 ARLINGTON, VIRGINIA ARLINGTON CEMETERY J. B. JENKINS FUNERAL HOME 21. Signature of Fun al Service Licensee 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPSIS disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Year Day 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📉 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 XINo 2 💢 No 1 ☐ Yes

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page 2 s

certificate

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The law requires that the death certificate be executed

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Division of Vital Records,

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Baltimore, Maryland 21215-0036

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated event resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 26. Place of Death (Check only one)

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 27. Manner of Death

1 XNatural

2 Accident

4 Homicide

3 Suicide

5 Pending investigation

1 npatient 28a. Date of Injury (Month, Day, 6 Could not be

Hospital

2 ER/Outpatient 3 DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

USN

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a, Certifie

determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and

THURBER

S. 31. Date filed (Month, Day, Year)

JUN 0 9 2009

0101240997 VA)

29c. License number

29d. Date signed (Mpnth, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CAPT

32. Registrar's

MC

NATIONAL NAVAL MEDICAL

BETHESDA MD 20889-5600

State Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	aryland		artment of I rtificate of				giene Reg. No.	2000	(9943
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Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)
JUN 0 9 2009

			For State Registrar	ate of Maryland		ertment of I etificate of			Re	g. No.	09	19944
	Physici	an	Decedent's Name (First, Middle, Last)		7	CC1			Date of Deatl	Davi	Year	3. Time of Death 6:05 P M
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	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Year	If Under 2		Date of Birth (Month, Day,		9. Birthp	place (State or Foreign
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9	after or ite	/Fu	1 Never Married 2 A Married 1	med Forces? Yes 2 No Yes, Give		r Yes, specify Cub I □ Yes 2 X No		, Puerto Ak	an, etc.)	Specify	k, White, Wh:	
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_	% ≨ % §	ž	29b. Signature and title of certifier	•		29c. Licen	-		2	9d. Date signe	d (Month,	Day, Year)
	30		PUMMIN THE	unka	W	DI	1170	7		6141	09	
			30. Name and address of person who complete Dr. Alan Kermaier	ed cause of death (Item 1 1400 Forest			200,	Silve	er Spri	ng, Ma	ry1ar	nd 20910
	Sta Registr		31. Date filed (Month, Day, Year) JUN 05 2009	32 Registrar's Signatu	pa	Med						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 6-9-09Amend#9.PerFHPGCcr Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death 2009 **Physician** JUNE 11: TO am Stafford D /Medical Lowry 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Doctor's Community Hospital Prince Georges Lanham | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country Wash D.C. Social Security Number **Funeral** 1 ☑ M 2 ☐ F 81 Months 10-18-1927 Director 259-32-6965 Usual Residence of Decedent Id be filed within 72 hours after death with the Maryland 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location r than "natural", or Items 23a or 28a-f shorthe Medical Examiner must be notified at 1x Yes 2 □ No Directo Lanham Prince Georges MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 20706 9402 Tuckerman Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Self-Employed Private is marked other Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Lowry Irma Simpson ၉ Pages 1 and 2 sho 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary A. Lowry / Wife 9402 Tuckerman Street Lanham MD 20706 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Brentwood MD Fort Lincoln Cemetery 6-12-2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityFort Lincoln Funeral Home 21. Signature of Funeral Service License Wash 3401 Bladensburg Rd Brentwood MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** HYHOXE Brain day 5 disease or condition resulting in death) /Medical Due (or as a consequence of): Examiner Cardiai Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No Day Month Year 5 Other (specify) Atter this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident after death Director: Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 29a. Certifier 1 Crifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 22/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LANHAM KO M.D THOMAS 8100 GOOD LUCK

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year 02 931 **Physician** June 200 RUIN 120 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Maryland Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Country) Days Hours Months 1072771967 220-02-4112 1⊠M 2□F 41 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b County 10a. State of Heath and Mental Hygiene. If Nem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at 28a-f shov 1 ☐ Yes XX No **Funeral Director** MD Anne Arundel Edgewater 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1497 Warfield Rd. 21037 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ∐Yes 2 ⊠ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify. Completed by 3 Widowed 4XDivorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Construction/ Electrical Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John McCarthy Shirley A. Tapscott ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John McCarthy Father P.O. Box 17 Mayo, MD 21106 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If Its any Injury or o Burial 2 Cremation 3 Removal from State Lakemont Memorial 6/9/2009 Davidsonville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Euperal Service Lie Tat Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** eria disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Physician/Medical Examiner it any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) P.O. | 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. ģ No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes Viital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA edical Certification: To Division of this Date of Injury (Month, Day, Year) nan er of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No Accident investigation hours after death. 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) / h. /n 24 hou.. 'se **Funeral Di**.. 'v filled in bv 4 Homicide Certifying Physician: To t > b st of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the base of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and annext stated. 29a. Certifier (Check only

Registrar

one)

30. Nam

29b. Signature and title

31. Date filed (Month, Day, Year)

JUN 05

Registrar's Signature

M.D

person who mplifted cause of death (Item 23a) (Type, Print)

M.D

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MOGELINSIGI Month 06 **Physician** 0405 GENEVIEVE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year, 12/7/1929 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 79 170-24-5433 Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h. County 10c. City. Town or Location 28a-f show traumatic event, the Medical Examinar a ust be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1635 St. Margarets Road items 23a 21409 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐Yes 2 No Specify. þ Specify: White 3 X Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygierial Inportant: If item 27 is marked other than any injury or other traumatic event, Ita Magnee. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At Home 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Molick Susan Kurty မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey Mogelinski/Son 20b. Place of Disposition (Name of cametery, crematory or other place)

1635 St. Margarets Rd. Annapolis MD. 21409

Date Date 20c. Rocation - City of rown, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Edgewater, Maryland Kalas Crematory 6/7/2009 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral Service Licensee 2973 Solomons Island Rd. Edgewater MD. 21037 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23a. Par 1. Enter the disease, or complicate shock, or heart failure. List only one Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 5 Other (specify) signed by the a d be detached for P.0. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ⋛ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No certificate has 1 ☐ Yes 2 🗷 No After this certific funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 5 Pending investigation 1 Natural n 24 hours at er death. e Funeral Director Af eletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) pletely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one)

Registrar

31. Date filed (Month, Day, Year) **JUN 05**

29b. Signature and title of cectifier

744 Registrar's Signature

V

Name and address of person w.o., impleted cause of death (Item 23a) (Type, Print)

29c. License number

ENSE

29d, Date signed (Month, Day, Year)

TNO APOUR MD21401

within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JUNE 2, 07:07 P.M OLGA MISRA 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ANNE ARUNDEL MEDICAL CENTER ANNE ARUNDEL ANNAPOLIS 8. Date of Birth (Month, Day, Year) JULY 11, 1930 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs, last birthday) Months Days Hours Min 1 □ M 2 🗙 F Yrs YUGOSLAVIA 78 068-66-6996 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No **MARYLAND** ANNE ARUNDEL ANNAPOLIS 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1610 TURKS CAP LILY LANE 21401 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) VOISLAV MOMIRSKI JELENA OSZTO 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GALI MISRA/DAUGHTER 1610 TURKS CAP LILY LANE, ANNAPOLIS, MD 21401 20b. Place of Disposition (Name of CHESTAPKAKE CREMATION CENTER 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State **2009** STEVENSVILLE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM 21. Signature of Funeral Service Licensee

Physician /Medical

Department of Health a Important: If Item 27 is any injury or other trau

Physician

/Medical

Examiner

10a. State

Director

Funeral

2

Completed

Be

Funeral

Director

and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

7 is marked other than "natural", or Items 23a or 28a-f sho traumatic event, Its Mudical Examinar must be notified at

is marked other than

Examiner

burial-transi attending physician for use as the burial signed by the a d be detached for page 2 should certificate completely filled in by the funeral director, within 24 hours after death.

To the Funeral Director: After this

Records, P.O. Box 68760,

the Hospital or Attending Physician:

2

Examiner Physician/Medical Be Completed by Certification: To Medical

Much Ethan	M00672	ROAD, ANNAPOLIS	, MARYLAND 21	401 BESTGATE
23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death. Do not e	enter the mode of dying, such as c	cardiac or respiratory arrest,	Approximate Interval Between
Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):			Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury	Due to (or as a consequence of):			
that initiated events resulting in death) Last	Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions con	tributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
ulcorative	ehiscence.		24a. Was an autopsy performed 1 □ Yes 2	
25. Was case referred to medical examiner?			of Death (Check only one)	· · · · · · · · · · · · · · · · · · ·
I tes 2 teno	ospital: 1 Inpatient 2 ☐ ER/Outpat	ient 3 ☐ DOA Other: 4 ☐ Nun	sing Home 5 Residence	6 ☐ Other (Specify)
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time Injury	of 28c. Injury at	28d. Describe how in	njury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
29a. Certifier (Check only one) 12 Certifying Phys 2 Medical Examin	ician: To the best of my knowledge, de ner: On the basis of examination and/or and manner stated.	eath occurred at the time, date and investigation, in my opinion, death	d place, and due to the cause h occurred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peterson

32. Registrar's Signature

D2408

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-04257 State of Maryland / Department of Health and Mental Hygiene Bette Jean Matthews Certificate of Death 1- For State Reg. No Registrar Time of Death 2. Date of Death I. Decedent's Name (First, Middle, Last) Physician/ Month Day May 28, 2009 1242 hrs Medical Examiner Bette Mathews 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Cecil Elkton Union Hospital 9. Birthplace (State or Foreign 8. Date of Birth (MM/DD/YYYY) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number 6 Sex **Funeral** Days Min. Hours Months Director 222-20-6527 75 04/14/1934 Wilm., DE **XX** M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 'n 10a, State Yes 2 X No DF. New Castle 28a-f shov Wilmington once, with the Maryland 10g. Citizen of What Country? 10f. Zip Code s 23a or 28a-f 10e. Street and Number USA 19807 111 Buck Road 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. or items the Medical Examiner must be Armed Forces? Never Married 2x No Yes Specify: Yes 2 X No specify: white If Yes, Give Year Widowed Divorced ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) it. Pages 1 and 2 should be filed within 72 hou timent of Health and Mental Hygiene. The file 2 is marked 2 is marked 2 is no house. Completed College (1-4 or 5+) Elementary/Secondary (0-12) Topco (Food Products) administrative Asst. 2 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Perce Malcolm Mildred Lowe (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address Alfred Lee Mathews 111 Buck Road Wilm., DE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition

1 Burial 2 Crer ltimore, crematory or other place) 6/8/2009 Removal from State Wilmington, DE Cremation 3 St. Joseph on the Brandywine Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licensee McCrery Funeral Homes, Inc. 3924 Concord Pike Part I. Enter the disease, or complications that caused the death. Do not enter the mild mild grant and provide respectively. Part I. Enter the disease, or company failure. List only one cause on each line.

Cardiac arrhytmia **Physician** Between Onset and Death Medical Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed 23a,27,permE, g893 7/7/09 TT Physician/Medical XUNPENDED physician a Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy Day Year Month 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Yes 2 No 3 Probably 4 ✔ Unknown è Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? has 1 🗸 Yes No ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical the Hospital or Attending Physician: Division of Vital Be Hospital: Other₄ Residence 6 2 V ER/Outpatient 3 Nursing Home 5 Inpatient After this No 1 V Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 27. Manner of Death Certification: 1 X Natural Yes 2 Pending Director: Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 24 hours after e Funeral Direc Could not be Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 29, 2009 O.C.M.E. Mas 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD. Assistant Medical Examiner 32. Registrar's Signature 31. Date filed (Month, Day, Year, State Registrar

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year George Kevin McConnell June 3 2009 03:50 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 11801 Smoketree Road Potomac Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1 □xM 2 □ F Director 78 022-22-8921 08/22/1930 Massachusetts Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits Examiner must be notified at Director 1 ☐ Yes 2X No MD Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with ō items 23a 11801 Smoketree Road Funeral 20854 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 0 /4 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Modical Evantmen once. 1948-1 XYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Amarried 2 | No Baltimore, Maryland 21215-0036 \$ 1 ☐ Yes 2 No Specify: 1950 Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)

Director of Weapons

Intelligence Central Intelligence Elementary/Secondary (0-12) College (1-4or 5+) 5+ Agency 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Kevin McConnell 2 Alice Silk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia McConnell (Spouse) 11801 Smoketree Road Potomac, MD. 20854 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State June 08 4 ☐ Donation 5 ☐ Other (Specify) 2009 Silver Spring, MD. Cemetery
22 Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Livense 23a. P. rtt. E. et the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, leart failure. List only one cause on each line.

Imme liate Cause (Final diseas or cer dition resulting in death)

a. Primary Central Narvous Such as cardiac or respiratory arrest, large such as cardiac or respiratory arrest, large 10 East Deer Park Drive Gaithersburg, MD. 20877 Approximate Interval Between Onset and Death **Physician** 10 Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the death certificate be executed and burial-trai Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death Month Day Year 5 ☐ Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ requires 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy certificate perform 1 ☐ Yes 2 XNo 1 ☐ Yes 2 🗆 No Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 | Yes 2 | XNo Other: 4 \(\text{Nursing Home} \) 5 \(\mathbb{Z} \) Residence \(6 \) Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day, Year) he Hospital or Attending P in 24 hours after death. he Funeral Director; After t pletely filled in by the funera 27. Manner of Death 28b. Time of After Certification: 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 🗀 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. Medical 29a. Certifier (Check only To the I within 2 29b. Signature and title of pertific 29c. License number 29d. Date signed (Month, Day, Year) D67258 June 03, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Farrell, M.D. 9707 Shady Grove Road, Suite#300 Rockville, MD. 20850 Nicholas J. 31. Date filed (Month, Day, Year Registrar's Signa 05 JUN Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jume 1,2009 9:00a **Physician** Malu Malu Tshiela /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Silver Spring Montgomery Holy Cross If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 1 / M3 10 / P1 9 667 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F Months Courtongo 42 Director 643-82-5463 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 28a-f show of 2 should be filed within 72 hours after death with the Maryla Ith and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examination and the notified at Gaithersburg Md Montgomery Director 1 ☐ Yes 2X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Congo 20879 20041 Mattingly Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Married 2 Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Home Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Jeanne Ngandu Dianda Malu Malu s 1 and 2 should b f Health and Ment tem 27 is marked ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20041 Mattingly Drive Gaithersburg, Md20879 Atembina Malu Malu/Sister permit. Pages 1 and Department of Healt Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/13/2009 Silver Spring, Md Gate of Heaven 4 Donation 5 ☐ Other (Specific Funeral Service Vice PHYTE TOPA OF SERVICE, P. A 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Septic shock /Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Breast cancer Physician: The law requires that the death certificate be executed Examin attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.0. ned by the 9 Unknown 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>გ</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an page 2 s autopsy performed certificate 1 XYes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No မ 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Date of Injury (Month, Day, Year) After t 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier è June 3,2009

Registrar

State

05 2009

31. Date filed (Month, Day, Year)



Glen Rd Silver Spring, Md.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Mental Hygiene State of Department of Health and Mental Hygiene Registrar Page 10-09, per Dr., HCHD a Registrar Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dev Year **Physician** 2009 BLANCHE MINKOFF /Medical June 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital 9. Birthplace (State or Foreign Country)

New York Social Security Number 6. Sex Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 K F Jan 30, 1917 Director 058-14-8065 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b County 10c. City, Town or Location ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examinat nual be notified at 1 ☐ Yes 2 XNo Director MD Frederick Adamstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with USA 3172 Blue Bell Court 21710 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed by 1 ☐Yes 2XNo Specify: Specify: White 3√2 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than 'any injury or other traumatic event, the Mesones. Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jacob Goldin Bess Levine ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marleen Peritz/daughter 40 Port Tack Hilton Head Island, SC 29928 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 06/07/09 Woodbine, MD Golfing and the screen Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examiner law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) P.O. I signed by the a 1 Tyes 2 DNO 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy After this certificate 1 ☐ Yes 2 ☐ No 2 No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check onl one) Be Hospital: 1 Yes 2 HNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ၉ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated

Registrar

SANDER

29b. Signature and title of certifier

SHARMA Registrar's Signature

, M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

400

00064624

MD

29d. Date signed (Month, Day, Year)

7th St Fredorick, MD 21701

Amend #1 per Phys Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. PGC 6/17/09 HH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Gundy Sophia Morris **Physician** 4:40 ΡМ Dorothy 2009 June 6, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Mitchellville Collington Episcopal Life Care If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dav. Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 □ M 2 🔯 164-54-8394 1914 McKeesport, PA 14, 94 June Director Usual Residence of Decedent 10d Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a. State ral", or items 23a or 28a-f show Examiner 6 ust be notified at 1 □Yes 2X No Directo Prince George's Mitchellville Maryland 10g. Citizen of What Country? 10e. Street and Number with USA 20721 10450 Lottsford Road Funeral Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🛛 No Specify: ģ White 3 X Widowed 4 ☐ Divorced 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than College (1-4or 5+) Elementary/Secondary (0-12) al Hygiene. Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Be Dorothy Wallace James Gundy ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6210 Belcrest Road, #1546, Hyattsville, MD 20782 Richard Morris / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Alexandria, Virginia Metropolitan Crematory 6/8/2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licenses 4739 Baltimore Avenue Lomos + Hyattsville, MD 20781 Gasch's Funeral Home, P.A. Wilmin 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2 Weeks Cerebrovascular Accident /Medical Due to (or as a consequence of): **Examiner** Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Vear Month Day in the past 12 months? 5 Other (specify) ed by the a 1 ☐ Yes 2 🖾 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Congestive Heart Failure 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Chronic Kidney Disease autopsy performed 1 ☐Yes 2 ☑No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 🖾 Nursing Home 5 🗌 Residence 6 🗍 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: A d in by the f 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Hospital 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only d manner stated. within 24

10 State Registrar 29b. Signature and title of ertific

31. Date filed (Month, Day, Year)

JUN 0 9 2009

William Francis Duboyce, 12158 Central Avenue, Mitchellville, MD 20721 37. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D47603

29d. Date signed (Month, Day, Year)

6/8/2009

1 - For Stat

Be Completed by Funeral Director

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Physician /Medical

Examiner

Funeral

Director

Medical Certification: To Be Completed by Physician/Medical Examiner

For State	State		•		Corti	ificate of	Dogt	th		_	M. O	000	7 1 2	10 -
Registrar 1. Decedent's Name (First, Middle)	le last)			,	Ceru	ilcate of	Deal		2. Date of I	Reg.	No.		3. Time	of Death
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a. Facility Name (If not institution	n, give street and r	number)			4	b. City, Town, o	or Locatio	on of Death				nty of Deat		
10920 Conne	cticut	Ave.	# 32	2 3		Kensi	_				Mon	tgam		
Social Security Number 216 – 58 – 6014	6. Sex 1 汉 M 2□ F		(In yrs. la:			If Under 1 Year Months Days			8. Date of 6	Birth Dy 9	3 1	9. Birt Ne	thplace (State ountry Y Or	e or Foreigi k
Jsual Residence of Decedent Oa. State 10b. County Md Monto	gomery		10c. City, Ken		or Locat ngt				_				10d. Inside	City Limits s 2⊠No
0e. Street and Number 10920 Connec	cticut ?	Ave	#323	3		10f. Zip Code 208	395			10g.		of What Co	ountry?	
11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 🖾 Widowed 4 ☐ Divorced	ried 1 □Yes	Forces? s 2 ½ 7N∈ Give			If Y	as Decedent of res, specify Cub	oan, Mexi	ican, Puerto	ecify Yes or Rican, etc.)	No-	E	Black, White	erican Indian, e, etc. IH ITE	
(Specify only highe		d) (1-4or 5+		16a. [Deceder (Give kir life. DO	nt's Usual Occu nd of work done NOT use retire	ipation during med)	nost of work	ing	16b		f Business/	•	
Elementary/Secondary (0-12)	College	(1-401 5+	-)	D:	ish	Washe	er					otel		
17. Father's Name (<i>First, Middle,</i> John Vincer		nias						other's Nam etty	e (First, Midd Maso		den Surn	name)		
19a. Informant's Name/Relations Veronica Nel		Sist	er			^{Address (Stree} Mounta							Zip Code) Md. 21	788
20a. Method of Disposition 1 ☐ Burial 2 【3 Cremation 4 ☐ Donation 5 ☐ Other (5)		m State	cei	metery	Dispositi	ion (Name of tory or other pla	ace)		Date 4/200				Town, State ille,	Μď
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21. Signature of Juneral Service		5	CHE	esa	pea PH	ke Cre	ss R fa	NA LD	I FUN	ERA	L S	ERVI	Œ,P.Z	A .
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State Registrar

31. Date filed (Month, Day, Year)

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2. Rogistrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician JUW 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE MARKLAND MEDICAL CENTER UNIVERSITY OF If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Dec. 3, 1956 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday Funeral 1 M M 2 □ F Months Days Hours 52 Maryland Director 214-52-0739 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. Count 10c. City. Town or Location 10a. State ral", or items 23a or 28a-f show Examiner is ust be notified at 1 ☐ Yes 2 ▼ No Crisfield Maryland Somerset Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 21817 26460 Main Street Extended U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 1∑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 r than "natural", or 1 ☐ Yes 2 X No 2 Specify Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Insurance & Real Estate Co. Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than amy injury or other traumatic event, the Monee. College (1-4or 5+) Owner 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Janet Lee Tull Donald Myron Price ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26460 Main St. Ext. - Crisfield, MD Janet Lee Price (Mother) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 6/9/09 St. Paul's Episcopal Cem. Marion Station, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of June al Service 22. Name and Address of Facility Ma Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, Robert H. Bradshaw, Jr Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Ceronary WRCH disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner myoure Squantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical attending p for use as t IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.O. signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed? 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 🛕 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral of 27. Manrier of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No nours after death neral Director: / filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 V ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

within 24 hos To the Fune completely fi

6 B State Registrar

31. Date filed (Month, Day, Year)
JUN 0 9 2009

29b. Signature and title of certifier

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M

32. Registrar's Signature

D62237

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Ye a Month **Physician** Michael В. Rodbell 8:17 P 03 2009 Tune /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Annapolis 1702 Foxgrape Lane If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 215–30–3837 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) July 03,1936 9. Birthplace (State or Foreign 6. Sex **Funeral** 72 Months Days Hours 1**X** M 2□ F Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location show th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Exections in the constituted at Anne Arundel Annapolis MD 1 ☐ Yes 2√ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21401 1702 Foxgrape Lane USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 □ No 196
If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1954 filed within 72 hours after 1 ☐ Never Married 2 X Married White Baltimore, Maryland 21215-0036 1962 1 ☐ Yes 2 No Specify: Completed by Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Manager of Transportation GE Corporation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental Samuel Rodbell Ida Yoffie ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: If Item 27 is any injury or other trau Doris S. Rodbell / Wife 1702 Foxgrape Lane Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition June 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Metro Crematory, INC. Baltimore, MD Signature of Funeral Service Licenses Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on _ach line. Immediate Cause (Final disease or condition resulting in death) **Physician** 18 MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it or you cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of The law requires that the death certificate be executed the burial-transit Exami and Due to (or as a consequence of). Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Day Year 5 ☐ Other (specify) signed by the a o 9 Unknown 9 🗌 Unknown <u>a</u> 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 Probably 4 Unknown 2 X No 1 ☐ Yes page 2 should Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 certificate 2 210 1 ☐ Yes after death.

Director: After this certificd in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 1 Yes 2 No Hospital: Other: 4 Nursing Home 9 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Hospital or Attending Natural Accident 5 ☐ Pending investigation 1 □Yes 2 □ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide e Funeral I 29a, Certifier **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and ti

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Year)

30. Name and add

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Month **Physician** Eugene Anthony Rochester June 2, 11:20 pM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Gaithersburg 18635 Carriage Walk Circle 9. Birthplace (St Country) Date of Birth (Month, Day, Year)
Tan. 3, 1 5. Social Security Number 7. Age (In yrs. last birthday) (State or Foreign **Funeral** Days Hours Min. Months 217-98-5561 Director 1942 Jamaica Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a.d. nary injury or other traumatic event, the Martin and injury or other traumatic event, the Martin and injury or other traumatic event, the Martin and injury or other traumatic event, the Martin and injury or other traumatic event, the Martin and injury or other traumatic event, the Martin and injury or other traumatic event, the Martin and injury or other traumatic event, the Martin and injury or other traumatic event, the Martin and injury or other traumatic event, the Martin and injury or other traumatic event, the Martin and injury or other traumatic event, the Martin and Martin an 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18635 Carriage Walk Circle 20879 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Multi-Racial 1 ☐ Yes 2 ANO Specify Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales & Consultant Automotive 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Henry Rochester Hyacinth M. Byndloss ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carmen Rochester/Wife 18635 Carriage Walk Circle, Gaithersburg, MD 20879 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State June 3, Metropolitan Crematory 4 □ Donation 5 □ Other (Specify) 2009 Alexandria, Virginia 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 rart 1 Enter the disease, or complication and at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest short, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic Gastro-Intestinal Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physiclan; The law requires that the death certificate be executed Chronic Anemia Due to (or as a consequence of) Box 68760. Physician/Medical Chronic Renal Insufficiency IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 512 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D63232 10

State Registrar

DHMH 17 Rev 1/2001

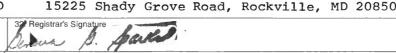
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Patricia Gomez,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12:46 ^{P M} **Physician** 05 2009 06 Cora Rose /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 5. Social Security Number Funeral Days Hours 1 □ M 2 🖾 F 10/08/1924 Turbeville, SC Director 250-42-7079 84 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lighty or other traumatic event, If a Medical Examiner must be active and 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 X Yes 2 □ No Director Washington DC 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3400 Commodore Joshua Barney Drive, NE Apt. 205W 20018 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ♣ No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed by 3 ☑ Widowed 4 ☐ Divorced Year or Dates Black. 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Federal Government Elementary/Secondary (0-12) College (1-4or 5+) DC Public Schools 12 Food Service Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Daisy Marie Player ပ္ Ervin Wesley Woods, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8436 New Hampshire Ave., Silver Spring, MD 20903 Geemellow Moore - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State Lincoln Cemetery 06/13/2009 | Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. 21. Signature of Funeral Service Licensee Jorga Montgomeny-Cheatlian 3401 Bladensburg Road Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 55 **Physician** /Medical Due to (or as a consequence of): Caydiovascular disen Examiner TOVOSA erohic Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed sician and burial-tran resulting in death) Last Due to (or as a consequence of): physician s the burial O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No 5 ☐ Other (specify) signed by the a 9 I Inknown 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ 2 No 3 Probably 4 Unknown 1 🗆 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy perform certificate 1 ☐Yes 2 ☐No 2 4No 1 □ Yes or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Hnpatient 2 ER/Outpatient 3 DOA After this c funeral dire Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner eath 28c. Injury at Work? 1 atural 5 Pending within 24 hours after use...
To the Funeral Director: Af 1 □Yes 2 □No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0060600 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THE IN A AHMED 2090 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 0 9 2009 Registrar

			For State Registrar	State of Maryla		artment of I rtificate of			-	Reg. No.	
	Physicia		1. Decedent's Name (First, Middle, Last RAYFIELD SIMPSON)					Date of Dea		3. Time of Death 4:23 A м
	/Medic Examin	-	4a. Facility Name (If not institution, give 3310 STUMP NECK			4b. City, Town, c				4c. County of D	
	Funeral Director				rs. last birthday) Yrs.	If Under 1 Year Months Days		Min. S	Date of Birl (Month, Da EPT	10, 1929 h	Birthplace (State or Foreign Country) ARYLAND
	yland III		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation					10d. Inside City Limits
:	28a-fsl	ector	MD CHARLES 10e. Street and Number	I	NDIAN H	EAD 10f. Zip Code				10g. Citizen of What	1 Yes 2 No t Country?
	23a or	al Dir	3310 STUMP NECK	ROAD		2064	0			UNITED ST	
036	should be filed within 72 hours after death with the maryland and Mental Hygiene. Marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examination in use to notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 A Yes 2 No If Yes, Give Year or Dates:	37T	Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 🛣 No			y Yes or No an, etc.)	Specify:	American Indian, White, etc. BLACK
Maryland 21215-0036	ne. ne. han "natur e Medical I	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation de completed) College (1-4or 5+)	(Give	edent's Usual Occu e kind of work done DO NOT use retire XPLOSIVE	during mos ed)			16b. Kind of Busine	GOVERNMENT
7 .	riled w I Hygie other ti ent, th	Be Co	17. Father's Name (First, Middle, Last)		15.	VI FOSTAE			First, Middle,	Maiden Surname)	OO VERNIEN I
ylan	Menta Menta Marked Marked	To B	PEARL SIMPSON	-10-10-11						IMPSON	7.041
<u>≅</u> :	d 2 s th al th al 7 ls trau		19a. Informant's Name/Relationship (7) CONSTANCE DIXON/DA							er, City or Town, Sta HEAD, MD	10640 (1906)
ore,	permit. Fages 1 an Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	20 Removal from State	b. Place of Dispo cemetery, cre	osition (Name of matory or other pla	ace)	Date		20c. Location - City	
altimore,	nt. Pages artment of ortant: If it injury or o		4 □ Donation 5 □ Other (Specify) M		2. Name and Addr		06/10		CHELTENH	AM, MARYLAND
Ba	Department and and and and and and and and and and	}	LYDIA C. THORN	TON JOHNSON M		2. Name and Addr IHORNION FU 3439 I.TV	INGSTO	ON ROAI	INI.	IAN HEAD,	MD 20640
P	hysician		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on each line.	eath. Do not er	nter the mode of dy	ing, such a	s cardiac or r	espiratory a	rrest,	Approximate Interval Between Onset and Death
E	/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):	100					Yeurs
	sit sit	iner	Sequentially list conditions, if any leading to firm ediate cause. Enter Underlying Cause (Disease or injury	D. Eule to (or as a con-	sequence off.	2.1					Yews
,097	ate be executed hysician and the burial-transit	ical Examiner	that initiated events resulting in death) Last	Due to (or as a const							
.O. Box 68	lo the host raid of Attending Prysician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1	etal death 3	☐ Ectopic pregnar ☐ Other (specify)				23d. Date o	
rds, P.	w requires that s been signed b should be deta	by	Part II. Other significant conditions of	ontributing to death but not	resulting in the I	underlying cause g	iven in Part	t I.			ute to the cause of death? Probably 4 Unknown
Division of Vital Records,	: The law rec cate has bee page 2 shou	Completed							24a. Was auto perfo 1 □ Yes	psy prio	re autopsy findings available or to completion of cause of tth? Yes 2 □ No
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	sician s certifi lirector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2	Z □ EB/Outpatie	ent 3 DOA Of	thor	ce of Death ((Specify) Hospice
on of	noing Pnysician: The th. : After this certificate h. s funeral director, page	ition: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Yea	28b. Time	of 28c. Inj		28		how injury occurred	(opcony) (op op op op op op op op op op op op op
Divis	al or Attend s after death al Director; , ed in by the f	Certification: To	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, si ecify)	treet, factory, office)	28	f. Location (City or To	Street and Number wn, State)	or Rural Route Number,
	Hospit 24 hour Funera stely fills	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my niner: On the basis of exar and manner stated.	knowledge, dea nination and/or i	th occurred at the nvestigation, in my	time, date opinion, de	and place, an eath occurred	nd due to the d at the time	cause(s) and manr date and place, and	ner as stated. d due to the cause(s)
	o the Hospital of γ within 24 hours after To the Funeral Dire completely filled in b	Mec	29b. Signature and title of certifier	\\	w	_	nse number			29d. Date signed (
1	BUE		30. Name and address of person who co	completed cause of death	(Item 23a) (Type	, Print)			1100	10/21 d = 6 A	10 20602
	OH. Sta	ite rar	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature			30,7	100	INWI	

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 31, 2009 11:35 € **Physician** Ellsworth Smith Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico 334 Troopers Way Salisbury If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 8. Date of Birth (Month, Day, Year) 12/28/1928 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days XXM 2 F 213-22-1714 80 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show if than "natural", or items 23a or 28a-f show 1 ☐Yes 2 ☐ No Maryland Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 334 Troopers Way 21804 USA death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filled within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any hiury or other traumatic event, it effection Evarities once. Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🛣 No White Specify: ≥ 3℃Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Detective AACO Police Dept. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ellsworth C. Smith SR. Hattie E. Sears 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Donna White Daughter 34739 Tingle Rd. Pittsville, MD_21850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/5/2009 Hillcrest Memorial Annapolis, Md 21. Signature of Funeral Service bicensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 70 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SYEARS Congestive negn /Medical Due to (or as a a nsequence of) **Examiner** Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Councun artem and Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical the as nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month be detached for Day Year 4 Pregnant at time of death 5 Other (specify) 1 □Yes 2 □No the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Clineir 1 Tyes 2 No 3 Probably 4 Hownknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform After this certificate 1 □Yes 2 ☑ No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dether (Specify) HOSPICE Hospital: 2 UNO ٩ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death. death. 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 🗕 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ledical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2009 UNE 2 Joney a. Wennic 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PODNEY A. WENRYH S. DIVISION ST. 1346 SALISBURY 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Eileen Dee Shea 2ัด็ด9 6:35 A M June 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery Manor Care Potomac Potomac If Under 1 Year 8. Date of Birth (Month, Day, Year) 01/11/1939 9. Birthplace (State or Foreign If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours Washington, DC 1 □ M 2 🖾 F 70 577-52-1017 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County ¥ Yes 2 No Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20015 United States 2971 McKinley Street NW Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∏Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married Married Specify: White 1 ☐ Yes 2X No Specify. 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ellen Mulvihill Jeremiah Dee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Thomas A. Shea / Son 18811 Porterfield Way Germantown, MD 20874 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 06/04/2009 Silver Spring, MD Heaven Cemet. 4 Donation 5 Dother (Specify) Gate of 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Licensee Willia-5130 Wisconsin Av. NW Washington, DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Colon Cancer disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) a I I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy autopsy performed? Ves 20 No 1 ☐Yes 2 ☐No 1 ☐Yes 26. Place of Death (Check only one)

Physician /Medical Examiner

permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai once.

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Certification: To

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and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene.

m 27 is marked other than "natural", or items 23a or 28a-f show ther traumatic event, the Medical Exercited at

Baltimore, Maryland 21215-0036

physician and s the burial-trans attending p signed by the a peen as e 2 s page certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification completely filled in by the funeral director.

requires that the death certificate be executed

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Box 68760.

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Division of Vital Records,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year) 28b. Time of Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Accident

4 Homicide

3 ☐ Suicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

JUN 04

29c. License number

29d. Date signed (Month, Day, Year) D0054566 6-3-09 01 bengia Au #1-17 Silver Spring MP002

30. Name and address of person who completed cause of death (Item, 23a) (Type, Print PR Sunita 1865) Sunitha 31. Date filed (Month, Day, Year)

and manner stated.

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No/ 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 400 ROLAND BURNELL TALLEY 02 2009 Une /Medical County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Center Contgomery Brook Growker bilitation and Nursing zend Some Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 5. Social Security Number Date of Birth (Month, Day, Year) Days Hours 1**∑** M 2□ F 26,1918 Maryland 218-07-6560 90 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 XYes 2 ☐ No Director Gaithersburg Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20878 14800 Jones Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2X No Specify: Specify: Black þ 3 Widowed 4 Divorced 43 - 45Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dept. of Navy Electrician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Laura Lee Richard Talley ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14800 Jones Ln., Gaithersburg, MD 20878 Elizabeth Talley 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Cem.6/30/09Arlington Nat. Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. So ature of Funeral Service Licent ee 22. Name and Address of Facility Snowden Funeral Home, PA 246 N. Washington ST Rockville MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Minutes Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 🗀 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4X Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed physician and is the burial-trans Division of Vital Records, P.O. Box 68760,

Physician /Medical

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventher must be netified at

Baltimore, Maryland 21215-0036

Examiner Physician/Medical 2 Be Completed

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after death.	Director; After this certificate has been signed by the attendi	d in by the funeral director, page 2 should be detached for use	- 1
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To the Hospital within 24 hours a To the Funeral Completely filled

1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier

attending 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

.D. 18100 Slade School Road Sand Drooke

31. Date filed (Month, Day, Year) 04 JUN

32 Registrar's Signatu

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death June **Physician** 2009 04 0700 Thomas Strand Weiss /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Westminster 227 Hobbitts Lane If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 XM 2 □ F 218-22-9545 81 MD 05 1928 **Director** Jan Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f sho The Medical Experien must be notified at 1 ☐ Yes 2 No Director Westminster MD Carroll 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 227 Hobbitts Lane 21158 Funeral Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
ant: if item 27 is marked other than "natural", or items 23a ury or other traumatic event, Ite Mediel Exercite man 12. Was Decedent Ever in U.S. Armed Forces? 1951 1 Byes 2 □ No If Yes, Give 1952 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Center for Medicaid Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emma Parker Alcuin Weiss 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Patricia J. Weiss/wife 227 Hobbitts Lane Westminster, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation, Inc 6/8/2009 Hampstead, MD 21. Signature of Juneral Service Licensee Prittes Tuneration Home and Chapel, P.A. alle 21157 412 Washington Road Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** /Medical resulting in death) Due to (or as a consequence of): PNEU MONIA Examiner 100 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or physician and the buriel-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 1 Yes 2 No 3 Probably 4 Unknown has been signed to be a should to be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate hi funeral director, page 1 ☐Yes 2 ☐No 1 ☐Yes 2 ☐No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manua of Death spital or Attending P nours after death. nerel Director: After t filled in by the funera 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 ☐ Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division of Vital Hospital

To the Hospital within 24 hours a To the Funeril Completely filled WIL

29b. Signatur and title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

555 S. Center Street Westminster, MD Flavio Kruter, MD

31. Date filed (Month, Day, Year) State Registrar

29a. Certifier

(Check or one)

Medical

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 2009 3:55A June 22, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Westminster Dove House Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) S. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Months Days Hours 1**X**M 2□ F 327-24-4130 Vrs Sept 21, 1929 IL 79 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show 1 ☐ Yes 2(X) No d other than "natural", or items 23a or 28a-f shevent, the Medical Examiner must be notified. Director Mt Airy MD Carroll the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with USA 21771 5408 Valley View Ct Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Dyes 2 No 1947 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 💢 🎇 o Specify. White þ 3 ☐ Widowed 4 ☐ Mivorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) سنا Wental Hygiene. 27 is marked other than "n" r traumatic even Elementary/Secondary (0-12) College (1-4or 5+) Railroad 12 Brakeman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Inmon ဥ Henry Armstrong 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a Department of Health Important; If item 27 any injury or other troops. 5408 Valley View Ct, Mt Airy, MD 21771 Michael Armstrong 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 XXBurial 2 ☐ Cremation 3 XXRemoval from State June 26, 2009 Palestine Cemetery Palestine, IL 62451 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funcial Service Gregory Fin 22. Name and Address of Facility Fink Funeral Home, P.A. M01148 426 Crain Hwy S, Glen Burnie, MD 23a. Part 1. Inter the deelase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, o heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final D0/5 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Jause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician; The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) s been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 sl autopsy performe 2 🗆 No 1 ☐Yes 2 No 1 ☐ Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗷 No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manuar of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No n 24 hours after death. He Funeral Director: A sletely filled in by the fu 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Division of Vital Records, P.O.

Box 68760,

Baltimore, Maryland 21215-0036

within 2

the

State Registrar

Medical

and manner stated.

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Umbedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

10059943

22,2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

gre. Suze 39 westminster MD 21157 295

29a. Certifier

(Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 0 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 19^{ay}, 2009 4:54PM June Charles Victor Abel /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore 403 Tide Water Lane Chase If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days FEB 17, 1947 Hours Maryland 214-44-8724 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 1 ☐ Yes 2 No "natural", or items 23a or 28a-f sl Director Baltimore Chase 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21220 USA 403 Tide Water Lane Funeral within 72 hours after death Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Yes 2 □ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: White þ If Yes, Give Year or Dates**Vietnam** 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry traumatic event, the Medical l 2 should be filed within h and Mental Hygiene. 7 is marked other than ' than, Elementary/Secondary (0-12) College (1-4or 5+) Construction 9 Painter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Gill Charles J. Abel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s.
Department of Health as
Important: if Item 27 is
any Injury or other trau 403 Tide Water Lane Chase, MD 21220 <u>Jeri Hood/sister</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 6/20/09 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee C. Todd Dring Cremation Society of Maryland, Inc. 299 Frederick Rd Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760 physician Physician/Medical the use as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? Day 5 ☐ Other (specify) signed by the a d be detached for 1 □Yes 2 □No Ö 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has autopsy performed? certificate 1 ☐ Yes 2 No al or Attending Physician: 1 s after death. Il Director: After this certifica ed in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospital: 1 | Yes 2 | Mo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined completely filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registrar DHMH 17 Rev 1/2001 29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUN 2 3 2009

Medical

Main St Reilter town MD 21136

and manner stated

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** HELMA SKINS 2009 Jun USTINE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Franklin 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 24 Hrs Social Security Number **Funeral** 213-34-312 SOUTH CAROLINA Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1**/** Yes 2 □ No MD BALTIMORE Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 6186 RADECKE 21206 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 ☐ No Completed by Is marked other than "natural", raumatic event, the Medical Exp イルSTING TSK Baltimore, Maryland 21215-00 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) NURSING Elementary/Secondary (0-12) College (1-4or 5+) NURSE ALD HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) WILDER MARTIN RICHBURG ARTHA ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BALT, MD 6186 RADEONE AVE KAREN MARIE BUSH DAU 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or of GARRISON FOREST VETERM. JUNE 27, 2009 OWING MISS, MO 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CARY L. ROLLING FUNDIAL HOME NO WIST SOUNT ST FROD GRUN MD 21701 21. Signature of Funeral Service Licensee neu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due o (or as a consequence of): Examiner mar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) signed by the a d be detached for ☐Yes 2 ☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 📉 No 3 Probably 4 Unknown icate has been si , page 2 should t 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 No certificate 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) this (Hospital: 1 Yes 2 No 2 ER/Outpatient 3 ☐ DOA 1 🗌 Inpatient Certification; To s after death.

I Director: After this of in by the funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours aft

To the Funeral DI

completely filled in Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number William andrew Keng 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR WILLIAM Rente 9000 Franklin 3 1000 Franklin

State Registrar Date filed (Month, Day, Year)

JUN 2 3 2009

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Funeral	-	5. Social Security Burneer	6. Sex 7. Age	(In yrs. last t	oirthday)	If Under 1 Year	If Under 2	24 Hrs.	8. Date of Birtl (Month, Day		9. Bir	rthplace (State or Foreign	n
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and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Loc	ation						10d. Inside City Limits	;
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er dea	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. V	Vas Decedent of H Yes, specify Cuba	lispanic Orig an, Mexican	gin? (Spec i, Puerto F	cify Yes or No- Rican, etc.)	1	 Race - Am Black, Whi 	erican Indian, te, etc.	
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2 hou	sted	15. Deceden	nt's Education est grade completed)	16	a. Deced	lent's Usual Occup	ation	t of workin	a I	16b. Kin	d of Business	s/Industry	
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Lally ideal to Z. I.Z. I.D. DOOD 2 should be filed within 72 hours after death with the Maryland 3 and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Even in Ermust be indiffed at	-	19a. Informant's Name/Relations	ship (Type. Print)	19	9b. Mailin	g Address (Street	and Numbe	er or Rura	l Route Numbe	er, City or	Town, State,	Zip Code)	
and 2 and 2 lealth m 27 I her tra		Merry G. Roe	Daughten	Jan. 51		Box 109,			<u>d MI 49</u>		cation - City o	r Town, State	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Recited Evention in must be rediffied at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation				sition (Name of natory or other place	ce)	June.	22,		imore Ci		
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ath certif	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			500					23d. Date of c	lelivery	
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at the d by the stache	Phys	9 □Unknown			- i= th=		on in Dart I		23e Did t	obaccou	se contribute	to the cause of death?	
ires th	þ	Part II. Other significant conditi	ons contributing to death bi	ut not resulting	g in the ui	nderlying cause giv	ven in Part i	l.	1 🗆	15		Probably 4 ☐ Unknow	vn
law requires that seem signed as been signed 2 should be considered.	eted								24a. Was		24b. Were	autopsy findings availab	le
he lav e has	Completed								auto perfo		prior t death	o completion of cause of	f
VICAL ilcian: T certificat ector, pa	Be C	25. Was case referred to medica	al				26. Place	e of Death	1 ☐ Yes (Check only o			2010	_
Physic Physic this ce		examiner? 1 ☐ Yes 2 No		ent 2 ER/		it 3 DOA			me 5 ☐ Res	_		pecify)	
Ing P	ion	27. Manner of Death 1 ★Natural 5 ☐ Pendi	28a. Date of Inju		b. Time of Injury	Wor	iry at rk?]Yes 2 □		28d. Describe	how injur	y occurred		
Vitending death. ctor: Afte y the fune	ficat	3 Suicide 6 □Could		ury - At home,	farm, str	eet, factory, office	1168 2					Rural Route Number,	12.3
al or /	Certification: To	4 ☐ Homicide deterr	building, et	c. (Specify)					City or To	wn, State)		
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bundary.		(Check only edica	ing Physician: To the best I Examiner: On the basis o	of examination	dge, deat and/or in	h occurred at the t	time, date a opinion, de	ind place, ath occurr	and due to the ed at the time	cause(s date and) and manner d place, and d	as stated. lue to the cause(s)	
thin 24	Medical	one) 29b. Signature and title of certific	and manner sta			29c, Licen						onth, Day, Year)	
₽ .≱ ₽ .8		Signature and title or certific	1 / .	1			5 00	~		- 1	,	2009	
T.		30. Name and address of person	n who completed cause of d	ho death (Item 23	a) (Type,	Print)					, ,		
V	1	Dr. Lee Li	9000 F	rank	lin.	Square	Dril	je [3altin	1010	, mī	01037	,
Sta		31. Date filed (Month, Day, Year	32. Registr	rar's Signature	base								
Regist	ar	JUN 2 3 20	119 Kenera	13. 19	-wu								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.) 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** : JJPM al 09 18 /Medical 4c. County of Death 4b. City, Town, or Location of Death Name (If not institution, give street and number) Examiner mem oria 0 Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min Months Days Hours 1 M mare Director Usual Residence of Decedent 0d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Nes 2 No **Funeral Director** 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 14. Race Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□ Yes 2 No Baltimore, Maryland 21215-0036 Specify. ۾ Divorced 3 Widowed Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, the Meone. Elementary/Secondary (0-12) College (1-4or 5+) 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ 19a Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) And Ville Gerald 20b. Place of Disposition (Name of 20c. Location -20a. Method of Disposition cemetery, crematory or other place) Burial 2 Cremation 3 F 3 Removal from State 21. Signature of uneral Service Lig-23a. Part . E/ te/ the diseas shock, or neart failure. disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat C use (Final disease or condition resulting in death) **Physician** HYTENSIUS /Medical Due to (or as a conseque! **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: ate has been signed by the attendin page 2 should be detached for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2□ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an certificate has autopsy Yes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA Certification: To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 Matural Natural 5 Pending investigation 1 Yes 2 No death. 2 Accident the within 24 hours after death To the Funeral Director; 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

4

30. Name and address of person

31. Date filed (Month, Da)

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** POSPICE OWS on If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Hours 32-7405 1 ☐ M 2 € E Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It is Maddeal Exist, instrume to notified at any Injury or other traumatic event, Its Maddeal Exist, instrumed to notified at 1 Nes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number -01 Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc I □ Yes 2 No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ZNo Specify. þ Specify: 3 Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) mad vuse i 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ansome OU ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) THA 4018 B. 2120 gaughter 20b. Place of Disposition (Name of cemetery, crematory or other p Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State lestorn 09 4 ☐ Donation _ 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Nallace 23a. Part 1. Enter the glease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER **Physician** ENDOMETRIAL MONTHS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to for as a consequence of: requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 💆 o Month Day Year 5 ☐ Other (specify) P.O. been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CARDIOMYOPATHI Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy page After this certificate funeral director, pag 2 No Division of Vital 1 □ Yes 2 No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 ☐ Yes _ 2 🗷 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: completely filled in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier JUNE 19, 2009

State Registrar 555 W TOWSONTOWNZLUD

TOWSON, MO 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIEUE DOBERMAN, MO

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician ELEN JUNE 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMIRE NOKTHWEST RANDALLITOWN HOSAITAU If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 6. Sex Social Security Number **Funeral** 1 □ M 2 🗰 F Days Hours . 60.05 10 Yrs. Director 28 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ita Modical Extra right in the Indiffed at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Los Angeles os Angeles 1 ☐ Yes 2 No Director 101. Zip Code 10e. Street and Number 10g. Citizen of What Country? 90003 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Black Specify: δ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Callege (1-4or 5+) Private Domestic Vear 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edna Mae Brown ea.mon မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Street LOAngeleo CA 40003 t W. 103rd low/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Whittier 06/27/09 Hills Momorial Park 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Vaughn C. Greene Funeral Sics 21. Signature of Funeral Service Licenses Vaushin Liberty Road Kandallstown MD 21133 23a. Part 1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such a cardiac or respiratory arrest, shock, or hear failers. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physiclan: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) P.O. Box 68760. Completed by Physician/Medical signed by the attending I be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 No 1 ☐Yes 2 ☐ No of Vital 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral. 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d, Describe how injury occurred Division 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital of within 24 hours a To the Funeral D 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year)

State

DHMH 17 Rev 1/2001

Registrar

29b. Signature and title of certifier

NHC Registrar's Signature 32

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NAVI

JUNE

Amend #30 Pwr DVR G892 6/23/09 JH
State of Maryland / Department of Health and Mental Hygiene 2 0 9 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) June 8, Year 2009 **Physician** 8:20 AM M Lillian E. Burnsteel /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick St. Catherine's Nursing Center Emmitsburg Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2X F 206-34-9993 Sept 16, 1921 Pennsylvania 87 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2√ No Director MD Frederick Thurmont 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21788 USA 8509 Links Bridge Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 11. Marital Status Black White etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify: white þ 3K Widowed 4 □ Divorced Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natu any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade com (Give kind of work done during most of working life. DO NOT use retired) grade completed) College (1-4or 5+) Elementary/Secondary (0-12) housewife own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frederick William Cullingford Ester Naomi Murray 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8509 Links Bridge Road Thurmont, MD 21788 Harvey L. Burnsteel/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 □ Other (Specify) 21. Signature of Funeral Stryice Sicenses State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD Approximate Interval Between Onset and Death ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part . Enter the disease, or complete shock, or heart failure. List only o Immediate e (Final disease or condition resulting in death) whit **Physician** mo /Medical Due to (or as a consequence of): Examiner cause that is the cause of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one examiner? Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 28c. Injury at Work? 27. Manner of D ath 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: Injury (Month, Day Year) 1 Natural 5 ☐ Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) dertifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21727 Allan Lee Carroll 310 S. Seton Ave Emmitsburg MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 1:50^P 18 2009 06 Yvonne E.Burress-Gibson 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Joseph Richey Hospice Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Months Days 1 ☐ M 2**X** F 219-58-1036 02/06/1951 58 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Ves 2 No Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3646 Lyndale Ave. 21213 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Francis Scott Key Elementary/Secondary (0-12) 1 2 t h College (1-4or 5+) Nurse Assistant Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Lomax Mabel Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Raymond Gibson/Husband 23rd St.Balto., MD, Ε. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 06/24/09 |Baltimore, MD Loudon Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licen 638 N, Gilmor St. Balto., MD, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ischenic Due to (or as a consequence of): 3 week Intertion Meniperce Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 1-12V /A103 Due to (or as a consequence of):

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending nhusician and the attending physician and hed for use as the burial-tran completely filled in by the funeral director, page 2 should

Box 68760

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Records.

vision of Vital

Physician

/Medical

Examiner

Funeral

Director

filed within 72 hours after death with the Maryland I Hygiene.

Baltimore, Maryland 21215-0036

in than "natural", or items 23a or 28a-f show

and Mental Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any linjury or other traumatic event one.

Physician

/Medical

Director

Funeral

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Completed

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MD

Examiner vsician/Medical

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ysicialiyid	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnat 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	I death 3 D Ectopie	c pregnancy (specify)		23d. Date of delivery Month Day Year	
	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the underlying	cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?	
200	End-ritage renal d	iseas (Hemotich	ysis XI ye	41)	1 ☐ Yes	2 No 3 Probably 4 Unknow	n
100	Commen adeig dis	دمه			24a. Was an autopsy performed	24b. Were autopsy findings availabl prior to completion of cause of death?	е
3	Church Levelitie C	with crishosis	l		1 □Yes 2 ☑		
0	25. Was case referred to medical			26. Place of Dea	ath (Check only one)		
2	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatient 3 □	DOA Other: 4 Nursing F	lome 5 ☐ Residence	6 Other (Specify) HOSPICE	
allon.	27. Manner of Death 1 ☑ Natural 5 ☑ Pending 2 ☑ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in		
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street, fact	ory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)	
and a		vsician: To the best of my know iner: On the basis of examinat and menner stated.				se(s) and manner as stated. and place, and due to the cause(s)	
Ä	29b. Signature and title of certifier		1	29c. License number	29d.	Date signed (Month, Day, Year)	

D 41476

#416 BALTIMORE MD

96018.2009

State

Registrar

6565 N CHARLESST.

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

W. WILSON

JUN 2 3 2009

RAYMOND

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 2009 Paul Donald Bertsch June 8:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 39 Gunnison Drive Aberdeen Harford | Flunder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov 3, 1930 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Ohio 78 297-22-5699 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or items 23a or 28a-f show r than "natural", or items 23a or 28a-f shor 1 ☐ Yes 2 No Director Aberdeen Maryland Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21001 **USA** 39 Gunnison Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2□No 1947 IfYes, Give Year or Dates: 1951 Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐Yes 2K No Specify. 2 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Map once. College (1-4or 5+) Electrician Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unk Unk 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) David Bertsch, Son 2955 Margate Court Abingdon, Maryland 21009 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State Metro Crematory Inc. 06/22/09 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licence Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Gastric **Physician** Ad eno Concinoma months /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>გ</u> 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s autopsy performed' 1 ☐Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D0037458 X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UnD. Dept For, lower land 29 S. Paca St. Baltimore, hut? 31. Date fled (Month, Bay, Year)

State

Registrar

JUN 2 3 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $2 \cap 9$ 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Dav Voor **Physician** 4:15 P JUNE RALPH COLEMAN BROWN 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 579-80-3550 1 ☑ M 2 ☐ F INASH NGTOW, DC Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Mexical Extrainer must be notified at once. 10a. State 1 Yes 2 No MD FREDER ICR FREDERKR Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number VERSON TORRACE USA 4300 Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 __Yes__2 __No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates 1 ☐ Never Married 2 1 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify Specify: BL KCK 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MERRILE College (1-4or 5+) Elementary/Secondary (0-12) PROPORTIES MANAGOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JACKSON RYLPH C. BROWN SR BEATRICE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) INDRSON TORRACE N. FLOODERLK MD Z1705 WIFE DENISE HALL BROWN 20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 20c. Location - City or Town, State 20c. Hocation - City or T 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility GARY L. ROLLINS FUN. HUMC 21. Signature of Funeral Service Lices ell 21701 sund. FREDERICK MD MO WOST SOUTH Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Chest Syndrome /Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any leading to minimize cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of To the Hospital or Attending PhysIcian: The law requires that the death certificate be executed within £4 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Sickle Cell Disease Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No q Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 ☐ Yes 2 🖾 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔼 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 2 3 2009

400 W 7th Street

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rohit Khirbat

D0067210

Frederick, Md

6/13/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 6:30 Ам Emma Martin Bowen June 19 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Arden Courts Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 ☐ M 2 🔀 F 91 Baltimore, MD Director 213-10-2314 March 2, 1918 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show ? is marked other than "natural", or items 23a or 28a-f shov traumatic event, the McCall Examinar must be in titled at 1 ☐ Yes ¾ No Director MD Baltimore Parkton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1515 Armacost Road 21120 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: White \$ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) iene. Law Elementary/Secondary (0-12) College (1-4or 5+) Legal Secretary 2 should be filed wind and Mental Hygier is marked other the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Martin Caroline E. Steubert ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sl
Department of Health an
Important: If item 27 is r
any injury or other traur 1515 Armacost Rd. Parkton, MD 21120 Albert Bowen/ Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Arlington National Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) Cemetery
Evans Funeral Chapel & Cremation Services
Monkton, MD 21111 21. Signature of Funeral Service Licenses 2 a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line.

Imm diate Causy (Final disease, or condition resulting in death)

a.

Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** MEARS /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760, the attending physician Physician/Medical the as 1 asn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 MNo 9 ☐ Unknown Month Year Day 4 Pregnant at time of death 9 Unknown 5 Other (specify) P.O. | signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 14553 Other: 4 Nursing Home 5 Residence 6 Cher (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To HVINY FACILITY 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 NORTH CHARLES ST SUITE 209 BALTIMORE, MD 21204 DANIEUE DOBERMAN, MO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

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		•	State Registrar			Cei	rtifica	te of	Death			Reg. No.	200	Q	19979
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	Physicia /Medic		Maurice M	latthew Boy	lan, Si	r.					June	20	2009		7:19 A.M
	Examin		4a. Facility Name (If not institutio	n, give street and nun	nber)		4b. City	, Town, o	r Location	of Death		4c.	County of D		
			Gilchrist	Gilchrist Center Towson						Baltimore					
	Funeral		5. Social Security Number	6. Sex 1 □ M 2 □ F	7. Age (In yrs.		If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	rth <i>ay, Y</i> ea <i>r)</i>	9.1	3irthpla Count	ace (State or Foreign ry)
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nd	3		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation							10	d. Inside City Limits
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Ne N	28a-f	Director	10e. Street and Number				10f 7i	p Code				10a Cit	izen of What	Count	rv?
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teg	is 23	Funeral	11. Marital Status	12 Was Dece	dent Ever in U.	S 13 1	Was Dece	dent of H	lispanic Or	rigin? (Spe	ecify Yes or N		14. Race - A		an Indian.
ter d	iter in	Fun	1 ☐ Never Married 2 ☐ Mar	Armed For	ces?		If Yes, spe	cify Cub	an, Mexica	n, Puerto	ecify Yes or N Rican, etc.)		Black, W	hite, e	
Irs at	P, 0	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv	e ates:		1 ☐ Yes	2 ∏No	Specify.	:			Specify:		white
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Sho	and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, If a Medical Expirimer must be notified at		19a. Informant's Name/Relations								al Route Num				
and 2.	n 27 ner tr		Patricia Came	nga/ daugh					Run Ci				Maryla		
5 - G	If iter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 ☐ Bernoval from 5	State Dua	Place of Dispo	sition (Na matory or	ame of other pla	ce)	June	24.		ocation - City		
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Dall	Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		21. Signature of Funeral Service	Licensee		Pe	2. Name a	ind Addre	ess of Facili	tive	s Fune	ral .	&Cirena	tic	n Ctr.,P.A
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			23a. Part 1 Enter the disease, o shock, or heart failure. Lis	r complications that ca t only one cause on ea	aused the deat ach line.	h. Do not en	ter the mo	de of dyi	ng, such as	s cardiac (or respiratory	arrest,			Approximate Interval Between Onset and Death
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o e e	attending physician and for use as the burial-transit			Cd.											
ficate	phy.	sician/Medica		d											
Cert	nding use a	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out			_						23d. Date of	delive	ery
death	atte d for	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 🗌 Pregr	oirth 2□Feta nant at time of o		⊒ Ectopic ⊒ Other (:		cy				Month		Day Year
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<u> </u>	n. After this certificate ha funeral director, page	ø	25. Was case referred to medica	al					26. Plac	e of Deat	h (Check only				i
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Y A	irect irect n by t	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	nined Zoe. Flace	of Injury - At h ng, etc. <i>(Speci</i>	ome, farm, st <i>fy)</i>	reet, facto	ry, office			28f. Location City or T	(Street a own, Stat	<i>nd Number</i> o e)	r Rura	l Route Number,
<u>ב</u>	urs af ral D	Š													
Hosp	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ledical	(Check only 2 Medica	ing Physician: To the I Examiner: On the b	asis of examina	ation and/or in	nvestigatio	on. in my	oninion de	eath occur	red at the tim	e, date ar	nd place, and	due to	the cause(s)
the	thin 2	Med	29b Signature and title of certific	and man	ner stated.		2	9c. Licen	se number			29d. D.	ate signed (M	fonth,	Day, Year)
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	Sta	ate	30. Name and address of person 31. Date filed (Month, Day, Year) 32 . R	egistrar's Signa	ature /	,0 1	,							
	Registr	rar	JUN 2 3	2009 Cen	wa p	1. Apa	Ne								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryland		ment of H icate of I			giene Reg. No.	009	19980
	Physici		1. Decedent's Name (First, Middle, Las) B	SURG	ESS		2. Date of Dea	Day	Year 2009	3. Time of Death 2.*20 A M
į	/Medio Examin		4a. Facility Name (If not institution, give GOOD SA WALTT			City, Town, or	Location of Death			ounty of Deat	
	Funeral Director		5. Social Security Number 6. Se		ast birthday) If	Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	Year 25	9. Birt	hplace (State or Foreign nuntry)
	aryland •how	10	Usual Residence of Decedent 10a. State 10b. County	10c. City	Town or Location						10d. Inside City Limits
	r 28a-f	Funeral Director	10e. Street and Number	(1)(1)		Of. Zip Code			10g. Citizer	n of What Co	
	ath with	ralD	1520 York R			212	12			USA	
5-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or floms 23a or 28s-f ehow event, the Madical Explains frust the Incillised at	à	11. Marital Status 12 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Amed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	If Ye	Decedent of H s, specify Cuba Yes 2 No	ispanic Origin? (Sinn, Mexican, Puert Specify:	pecny Yes or No o Rican, etc.)		Race - Ame Black, White pecify:	
15-0	n 72 ho "natur	leted	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Decedent' (Give kind	s Usual Occup of work done o NOT use retired	during most of wor	king		of Business/	
212	filed withi Hygiene. other than out, the M	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Fas	ter Ca	re		V;1	la M	are
Maryland	should be filed within nd Mental Hygiene. I marked other than Imatic event, the Manatic e	To Be (17. Father's Name (First, Middle, Last) Ed Burges	S				ne (First, Middle, Evans		imame)	
Mar	2 4 5		19a. Informant's Name Relationship (7	ype, Print)	19b. Mailing A	ddress (Street	and Number or Ru	ral Route Number	or, City or T	own, State, 2	Zip Gode) 2/2/8
ore,	es 1 and of Heelth f Item 27 r other ti		20a. Method of Disposition	20b. P	lace of Dispositio emetery, cremato		(a)	Date	20c. Loca	tion - City or	Town, State
Itimore,	it. Peges rtment of I rtant; If Its njury or o		4 □ Donation 5 □ Other (Specify		4+ Zi	ma and Addra	6-2	1-09	Dalti	MOre	y Marylang
	Departi Departi Importi eny Inj pnce.		21. Signature of Funeral Solvice Licen	Trun	490	5 YOUK	ss of Facility VQ KA. Ra	Himore	. Ma	rapro	1 2/2/2
-			23a. Part1. Enter the disease, or composhock, or heart failure. List only of	lications that caused the death	n. Do not enter th	ne mode of dyin	g, such as cardiad	or respiratory ai	rest, (Approximate Interval Between Onset and Death
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. METASTA Due to (or as a consequ		CERL	TCHL	CHINC	1-7	•	
ı	Examiner	_	Sequentially list conditions,	b. Due to (or as a consequ	Hence Off.						
	d d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C Due to (or as a consequ	derice ory.						
8760,	ficate be executed physiclen end is the burial-transit		resulting in death) Last	Due to (or as a consequ	uence of):						
687	ificate I g physies the t	edical		d							E-1242 E
BOX	death certific ettending p	lan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal	Ideath 3□Ect	opic pregnancy	,		230	d. Date of de	livery Day Year
P.O. Box	thet the death cer ed by the ettendin detached for use	ysici	1 Yes 2 No 9 Unknown	4□Pregnant at time of de 9□Unknown	eath 5⊡Oth	her (specify)					22,
	89 P 99	Completed by Physician/M	Part II. Other significant conditions of CELEBLOVA					11-11-1	obacco use Yes 2 🗆 i		o the cause of death?
eco	e law requir hes been si je 2 should	piete						24a. Was	an a	24b. Were at	utopsy findings available completion of cause of
a R	ician: The l certilicate he rector, page	e Con	25. Was case referred to medical					1 ☐ Yes	212 No	death? 1 ☐ Yes	2010
₹	S 2	To Be	evaminer?	Hospital: 1 Inpatient 2	ER/Outpatient :	3□ DOA Oth		ath <i>(Check only o</i> lome 5 ☐ Resi		Other (Spe	ocify)
0 00	g te		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Oate of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor M 1	y at k? Yes 2 ∐No	28d. Describe	now injury o	occurred	
Division of Vital Records,	To the trospitel or Attending P within 24 hours efter death. To the Funeral Director: After to completely filled in by the funeral	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify			765 2 110	28f. Location (: City or To		Number or R	ural Route Number,
	n Taspita 124 hours Funeral letely filler	Medical C	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	rsician: To the best of my kno iner: On the basis of examinal and manner stated.	wledge, death oc tion and/or invest	curred at the tir igation, in my o	ne, date and place pinion, death occu	a, and due to the urred at the time,	cause(s) ar date and pl	nd manner as lace, and due	s stated. e to the cause(s)
	To the To the comp	Me	29b. Signature and title of certifier	-1		29c. Licens					th, Day, Year)
,				web, mp	1 22a) (Tuna - Data		001+0	57	JUNF	-,21,	2009.
			LOPLAINE OF O	21-AUXIAH, my	5430	CAMPB	ELL BLUI	D. STE 2	14. BI	ALTIM	OKE MO21236
	Sta Registr		31. Date filed (Month, Day, Year)	82` Registrar's Signa	harke	,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Day **Physician** 1506 BUTHONS 200 buglas /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 9. Birthplace (State or Foreign aurel Regional HOSD, to Q If Under 24 Hrs. 8. Date of Birth Feb 27, If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Coonecticut 1∭ M 2□ F 60 Director 532-54-3307 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2 No Laure1 Maryland Howard Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

nt: If item 27 is marked other than "natural", or items 23a or ral", or items 23a or Examiner must be USA 20723 9015 N. Laurel Rd. Apt K Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 □ No If Yes, Give X Year or Dates: 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical College (1-4or 5+) Elementary/Secondary (0-12) Electronic Technician Electronic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jean Maria Dermott Frank Malcolm Burhans 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health a
Important: If item 27 is
any injury or other trau 9015 N. Laurel Rd. Apt K, Laurel, MD 20723 Jeffrey Burhans— brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 To Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD Atlantic Crematory 6-23-2009 22. Name and Address of Facility 21. Signature of Furneral Service Licenses Fleck Funeral Home, INC. 7601 Sandy Spring Rd., Laurel, MD shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) asdiac /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it is a sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4□Pregnant at time of death signed by the a d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 10 r this certificate has ral director, page 2 autopsy performa bes, to 1 ☐ Yes 2 🗌 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner?
1 Pres 2□ No Denie 26. Place of Death (Check only one) Be Other: 2 No Denied 2 DOA 3 DOA 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural
2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and tittle of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7100 Contee Rd Laurel

State Registrar

DHMH 17 Rev 1/2001

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31. Date filed (Month, Day,

			For State		State	of Mai	ryland	/ Depa	artment of Hetificate of L	ealth a Death	ind Me	ental Hy	/gien Reg. N		9	19982
			Registrar 1. Decedent's Name (First, Mic	idle, La	st)				imodio oi E		2	2. Date of D	eath			3. Time of Death
П	Physici		Mary E		Brown							Month June		2009 Y	'ear	6:00 PM
ji.	/Medic		4a. Facility Name (If not institu			umber)			4b. City. Town, or	Location of		June		lc. County of	Death	3.002
	Examin	er		_			tor		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				ŀ	N/A	٨	
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			Usual Residence of Decedent			1										
	ylany		10a. State 10b. Cou	nty			10c. City,	Town or Lo	cation						1	Od. Inside City Limits
	Mar	Ş	MD N/	A			В	altim	ore							1X Yes 2 □ No
	h the	Director	10e. Street and Number						10f. Zip Code				10g. C	Citizen of Wh	at Cour	itry?
	23s c		2111 Westfi	e1d	Ave.				21	214				USA	A	
	eep E	Funeral	11. Marital Status		12. Was De Armed F	cedent Ev	ver in U.S.	13.	Was Decedent of Hi f Yes, specify Cubai	spanic Orig	gin? (Spec . Puerto R	ify Yes or Nican, etc.)	lo-	14. Race -	Amend White,	
9	or it		1 Never Married 2 N			2 📉 No	0		1 □ Yes 2 No					Specify:		
ğ	ural',	d by	3 🖾 Widowed 4 □ Divord		Year or	Dates:										
ν Ω	72 h	Completed	15. Deced (Specify only hig			1)		16a. Deced	ient's Usuat Occupa kind of work done d DO NOT use retired,	ition <i>Juring m</i> ost	of working	2	16b.	Kind of Busi	ness/Ind	dustry
2	Mithin Pan Pan	Id III	Elementary/Secondary (0-12	!)		(1-4or 5+	-)			,				,	`	**
7	lled v Hygie ther t		10 17. Father's Name (First, Midd	le l'ast		/A		НО	memaker	18 Mothe	r's Name /	First Middl	e Maide	en Sumame		Home
ä	ould be filed within 72 hours after deeth with the Maryland Mental Hygiene. arked other than "natural", or iteme 23e or 28e-f ehow afto event, the Modical Exaction of the confiled at	Be								10. 1000110						
Ë	2 should be filed within 72 hours after deeth with the Marylan and Mental Hygiene. Is marked other than "naturat", or iteme 23s or 28s-f show aumatic event, the Modical Exacting retrivative routified at	٢	George H. Dur 19a. Informant's Name/Relation				-	10b Mailie	ng Address (Street a	and Alumba		a M.			tate Zin	Code
Z Z	12 st h and 7 is r traur	r i														
e,	1 and Healt em 2 ther		Jean M. McDona 20a, Method of Disposition	ara/	Daugnt	er	20b. Plac		Westfiel sition (Name of					MD 2: Location - C		
چ	ages or or		1 X Burial 2 ☐ Crematic			n State	New	Cathe	natory or other place drai	9)	June	20,			•	
Baltimore, Maryland 21215-0036	rtmer rtmer rtent njury		4 □ Donation 5 □ Other				Ceme	_	Nome and Address	o of Engilib	2009			Balti		
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If Item 27 is marked eny injury or other traumatic ex <u>once</u> .		21. Si de oi Figural Serv	196	IVA	∵ C1a	ary	Lé 10	Mame and Address mmon Fune W. Padon	ral F	lome o	of Dui	lane ium,	y Vali MD 2	Ley, 1093	Inc.
			23a. Part1 Enter the rise se shock, or hear ailure. I	or com	plications that	caused to	the death.	Do not ent	er the mode of dying	g, such as	cardiac or	respiratory	arrest,			Approximate Intervat Between
	Physician	11 1	tmmediate Caus (Final disease or condition			FIL	1	54	age 1.	Den	0-2	tic				Onset and Death
	/Medical		resulting in death)		Due to	o (or as a	conseque	nce of):	/							
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50,	cien s	<u> </u>	rosaning in additity East		Due to	o (or as a	conseque	nce or):							- 3	
8760	Attending Physicien: The law requires that the death certificate be executed riceath. ector: After this certificate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit	dicai			_ d										-	
×	eath certific attending p	Physician/Me	IF FEMALE:		23c. If yes, o	outcome o	of pregnance	cv						23d. Date	of detive	201
Вох	atten for u	clar	23b. Was decedent pregnant in the past 12 months?		1 Live	birth 2	2 ☐ Fetat d time of dea	leath 3[Ectopic pregnancy Other (specify)					Mont		Day Year
o.	that the de led by the a detached f	iysi	1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown		9□ Unk											
<u> </u>	that led by deta	ā	Part If. Other significant cond	litions	contributing to	death but	t not result	ing in the u	nderlying cause give	en in Part I.		23e. Did	tobacc	o use contrib	oute to t	ne cause of death?
g	w requires that s been signed I should be det	d by										10	Yes	2 □ No 3	Prob	oably 4 Honknown
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á	i 를 늘 드	Certification:	4 Homicide		buil	iding, etc.	. (Specify)					City or 7	own, St	are)		
	To the Hospital or Attending Physician: The law within 24 hours effer death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical (29a. Certifier 1 Certi (Check only 2 Medi	lying Pl cal Exa	miner: On the	he best of basis of a anner stat	examinatio	ledge, deat on and/or in	h occurred at the tim vestigation, in my op	ne, date an pinion, dea	d place, a	nd due to th d at the tim	e cause e, date a	e(s) and man and place, ar	ner as s	tated. the cause(s)
	Fo the within Fo the	Me	29b. Signature and title of cer				//		29c. License		_			Date signed		
			Tenar	er_		Ja	Lun	10	058.	570	7		J	une	17	2009
			30. Name and address of pers	on who	completed ca	use of de	eath (ttem 2	23a) (Type,	Print) Good S.	6 ~ 10 /	. /4	N	Ba	Itin.	10	
	Sta	ate.	31. Date filed (Month, Day, Yo	ar)	32.	Registra	ست r's Signatu	re .	1							
	Regist		JUN	237	2009	Sinse	ررم	B. B	and							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5 perFh G892 6/26/09 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Month Day 2009 June 18, 6:20 A M Mary Agnes Brown 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 14204 Dove Creek Way #205 Baltimore Sparks If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 21, 19 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Min. Months Days Hours 1 □ M 2 🛣 F 78 1931 Maryland 216-58-0951 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ∐Yes 2√∑ No MD Baltimore Sparks 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 14204 Dove Creek Way #205 USA 21152 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🛣 No Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Patrick C. Phelan Marv J. Peach 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerald R. Brown/Husband 14204 Dove Creek Way #205 Sparks, MD 21152 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State June 20. 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 2009 Baltimore, MD Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Road Timonium, MD 21093 21. Signature of Funer Inc. Mignael Flagle 23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on jach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ocava Due to (or s a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregrant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy perform 1 ☐Yes / 2l🗆 ! 25. Was case referred o medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Many r of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No

Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-tran Division of Vital Records, P.O. Box 68760, attending physician the for use as cate has been signed by the page 2 should be detached After this certificate within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Examiner Physician/Medical ۾ Completed Be Certification: To

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

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Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medica.

Physician

/Medical

filed within 72 hours after death

Baltimore, Maryland 21215-0036

3 ☐ Suicide 4 ☐ Homicide 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier

2 Accident

31. Date filed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

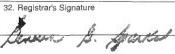
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Francis X. Carmody, Sr., M.D. 7505 Oslar Dr. Suite 212 Towson, MD 21204

State Registrar

6 ☐Could not be

determined



DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** AM 0148 Willard F. Bryant Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death Examiner Butmore osedate Franklin Sauare Hospita 8. Date of Birth (Month, Day, Ye OCT 12, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 443–38–2836 **Funeral** Months Hours 1 XM 2 F Days 937 Yrs. 71 Director OK Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, I'w Mod an Examiner must be notified at 1 ☐ Yes 2 ☑ No Essex Director Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21221 Cedar Avenue 411 Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 √Yes 2 ☐ If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Shipping Co. Traffic Manager 1yr and Mental Hygie is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be Erma F. Minnick Willard O. Bryant 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 411 Cedar Avenue Baltimore MD 21221 Victoria Bryant /wife 27 permit. Pages 1 and Department of Heal Important: If item 2 any injury or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart of Jesus 6/25/09 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 300 MAce Ave. Balto. MD Colux Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or commendations that caused the meath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only or e cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MAIAC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ardin Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 □Yes 2 ☑No Pregnant at time of death 5 Other (specify) o the 9 Unknown 9 Unknown à σ. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown icate has been si , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 ∐Yes 2 ⊠No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔯 No 1 🔲 Inpatient 2 → ER/Outpatient 3 DOA Certification: To this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only and manner stated. To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

Bryant, Will

ORIGINAL

9000

EVELINE

Franklin

√32. Registrar's Signature

Drive Baltimore MD 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

,			For State Registrar	State of Ma	aryland /		rtment of Hertificate of D			giene Reg. No. 2	009	199	86
п	Physicia	'n	1. Decedent's Name (First, Middle, La						Date of Dea Month	Day	Year	3. Time of De	eath M
	/Medic			ARTLEY					MAY 3		009	1357	IVI
	Examin	er	4a. Facility Name (If not institution, giv		λΤ.		4b. City, Town, or TAKOMA				y of Death	Y	
	F1		5. Social Security Number 6. 5		e (In yrs. last	birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	9. Birthp	place (State or F	oreign
	Funeral Director			1□M 2 ² CIF		3 Yrs.	Months Days	Hours Min.	(Month, Da MAY 19,	1976	WASH.	INGTON,	DC
	p.		Usual Residence of Decedent		10.05.7						11	0d. Inside City I	Limits
	arylar show	Ž	10a. State 10b. County		10c. City, To							1 XYes 2	
	he Ma 28a-f	Director	MD PRINCE G.	EORGE'S	HYATT	SVILI	LE 10f. Zip Code			10g. Citizen of	What Cour	ntry?	
	a or 2	Ö	10e. Street and Number 4922 LASALLE RD				20782			UNITED		-	
	ns 23	Funeral	11. Marital Status	12. Was Decedent B	Ever in U.S.	13. \	Nas Decedent of His	spanic Origin? (Sp	ecify Yes or No	- 14. Ra	ice - Americ	can Indian,	
920	be filed within 72 hours atter death with the Maryland Hygiene. A let Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Everine must be multibed at	þ	Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ XI If Yes, Give Year or Dates:	10		f Yes, specify Cubar I □Yes 2⊠No	Specify:	Hican, etc.)		ack, White, o ify: BLAC		
5-0036	'2 hou nature lical E	Completed	15. Decedent's E (Specify only highest gr	ducation	.1	6a. Dece	dent's Usual Occupa kind of work done di	ution	ina	16b. Kind of E	3usiness/In	dustry	
2	ithin 7 ne. nan "r	nple	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. I	OO NOT use retired)			NURSI	NTC'		
21	filed w Hygiei ther ti		12	1)				NURSING 18. Mother's Name					
anc	be od o	Be o	17. Father's Name (First, Middle, Last LESTER BARTLEY	/				FLORENCE			,		
Maryland	s 1 and 2 should be t f Health and Mental item 27 is marked o other traumatic eve	우	19a. Informant's Name/Relationship	(Type, Print)	- 11	19b. Mailir	ng Address (Street a	and Number or Rur	al Route Numb	er, City or Tow	n, State, Ziş	o Code)	
	and 2 s ealth ar n 27 is her trau		CYNTHIA L. ROBIN		4.4		PAUL DR. (
ē,	es 1 ar of Hea fitern rothe		20a. Method of Disposition				sition (Name of natory or other place		Date	20c. Location	- City or To	own, State	
Ë	Pages nent of int: If it iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		1	ONY I	MEM. CEM.	6/13		LANDOV	ER, M	D	
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature Funeral Service Ace	nsee	10/10		2. Name and Addres				2000	2	
			23a. Part 1. Enter the disease or con	nplications that caused	the death.	not ent	er the mode of dying	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Betwe	en.
	Physician		shock, or heart failure. I is only	one cause on each/lir	/	151	(Onset and De	ath
	/Medical		disease or condition resulting in death)	Due to (or as	-	ce of):		,					
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687	ificate g phy is the	edical		d				-115				781.	
O. Box	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal de	eath 3[☐ Ectopic pregnancy ☐ Other (specify)				Date of deliv	very Day Ye	ar
<u>.</u>	that the ed by detac		Part II. Other significant conditions	contributing to death be	ut not resultin	ng in the u	nderlying cause give	en in Part I.	23e. Did 1	tobacco use co	ntribute to	the cause of dea	ath?
ds.	uires that n signed b Id be det	d by							1 🗆	Yes 2 No	3□ Pro	bably 4 ☐ Un	ıknown
Division of Vital Records,	Hospital or Attending Physician: The law requires that the 44 hours after death. Funeral Director: After this certificate has been signed by the funeral Director: After this certificate has been signed by the tely filled in by the funeral director, page 2 should be detached.	Completed			-			<u></u>		psy ormed?	prior to co death?	opsy findings av	ailable use of
ā	sician: The certificate rector, pag		25. Was case referred to medical					26. Place of Dear	1 □Yes th <i>(Check only o</i>	2 ☑ No one)	1 □Yes	≱ ALINO	
<u> </u>	Physicia this cer al direct	o Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2 ER	l/Outpatie	nt 3 DOA Othe	er: 4 Nursing H	ome 5 ☐ Resi	idence 6 🗆 C	other (Spec	ify)	
0	ding Ph h. After th funeral	T:uc	27. Manner o Leath 1 Uldural 5 ☐ Pending	28a. Date of inju (Month, Da	ry 28 y, Year)	Bb. Time o	f 28c. Injury Work	y at ?	28d. Describe	how injury occ	urred		
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Š	lor Att after d Direct I in by I	Certification: To	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined	28e. Place of Inju	ury - At home c. <i>(Sp</i> ec <i>ify)</i>	e, farm, str	eet, factory, office		28f. Location (City or To	Street and Nur wn, State)	nber or Rur	ral Route Numb	er,
h	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C		hysician: To the best miner: On the basis o and manner sta	of examination								
9	To the within 2 To the comple	Me	29b. Signature and title of certifier	A.		^	29c, License			29d. Date sig	ned (Month	, Day, Year)	
)	1	MI			066010		05		7)	
			30. Name and address of person who 31. Date filed (Month, Day, Year) JUN 23 200	completed cause of d	leath (Item 23	3a) (Type,	Print) TAH	int M	0 12096	Ald mit	20		
	Sta Registr		31. Date filed (Month, Day, Year)	9 Aregistr	ar's Signature	par	Ked						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 6 09 1:10 Campbell Joanna /Medical 4c. County of Death Facility Name (If not institution, give street and number) **Examiner** Baltimore and beck Social Security Number last birthday) Birthplace
 Country) (State or Foreign **Funeral** Days 219-32-9256 1 □ M 2 😿 F Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Exercited must be notified at once. 1 ☐ Yes 2 ▼ No Director 10g. Citizen of What Country? 10f Zin Code 21207 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No \$ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use nettred) 16b. Kind of Business/Industry Elementary/Secondary/(0-12) College (1-4or 5+) 7 Father's Name (First, Middle, Last) onesome of and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State 21. Signatur o Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off: the attending physician and hed for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy 2 40 1 ☐ Yes 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 -No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier

Hospital or Attending Physician: The law requires that the death certificate certificate Division of Vital this After t within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

be executed

Box 68760,

P.O.

Records,

Baltimore, Maryland 21215-0036

State Registrar

PHYSICIAN

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1940 W. BALTIMORE

ST. BALTIMORE, MO 21223

SANDHU 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM# 20a-ca#22, perFH, 8893, 7/11/09, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.... 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** P M9:00 June 14, 2009 James Canada /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Cecil Sunbridge Rehabilitation Center E1kton | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | April 16, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Months New York 1 ☑ M 2 ☐ F April 1964 Director 094-52-7672 Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 10a. State show th and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 No Director E1kton Cecil MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21902 1 Price Street Funeral death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married Specify: black 3altimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: 2 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) law enforcement police officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Daisy Nedd James J. Canada ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a 658 Otsego Street #1 Havre de Grace, MD 21078 Department of Health Important; If item 27 any Injury or other troone. Susan White/sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Suse (Final disease or condition resulting in death)

23. Name and Address of Facility Caff a Stephen Baltimore, Maryland 21201 8/a

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Suse (Final disease or condition resulting in death) Chesapeake Crem. 07-07-09 Beltsville, MD 4□Donation 5₺Other (Specify) in state 22. Name and Address of Facilitala/Stephen D., Lohrmann P.A Maryland 21201 Baltimore, and 21286 Approximate Interval Between Onset and Death **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician; The law requires that the death certificate be execute physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No 2 100 1 □ Yes 1 ∐ Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation after death.

Director: Af
d in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in I within 24 hours at To the Funeral D completely filled i 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 16/09 100 65733 Y.V. Namya D. MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21921 ELKTON, MD RAO. V. PULA STREET NARAZANA 126 A E. 4764

State Registrar

DHMH 17 Rev 1/2001

32. Registrar's Signature

09-04832 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Bruce M. Carlin State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month **Medical Examiner** Bruce Myron Carlin 1650 hrs June 18, 2009 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 1200 Tollgate Road Harford 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) if Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Days Months Hours Director 1 X M 2 F 11-18-1947 Country) MD 218-46-4124 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Yes 2 X No 28a-f show Harford Bel Air Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant. If them 27 is an arked other than "natural", or items 23a or 28a-f sho rother traumatic event, the Medical Examiner must be notified at once. notified at once, Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21014 USA 1200 Tollgate Rd Funeral 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian, Black, Armed Forces' White, etc. Never Married Married 2 X No Yes 4 X Divorced Yes 2 X No specify: If Yes, Give Year White Specify: ≥ 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Harford County Gov't Homeland Security 2 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Arthur Carlin Edith Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Beam (Daughter) Baltimore, MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State rtment of He rtant: If ite y or other to crematory or other place) X Burial 2 Cremation 3 Removal from State 06-24-2009 Mtn. Christian Church Joppa, MD Depation 5 Other Specify 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Lice Inc 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and Medical a. Contact Gunshot Wound of Head Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical UNPENDED AMENDED ending physician use as the burial of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown page 2 should be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 ✔ No 3 Probably 4 Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy has death? certificate 2 No ✓ Yes 2 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other, Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene this ဥ 1 🗸 Yes funeral 28a. Date of Injury FOUND: After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject shot self Division 1 Natural FOUND: Yes 2 🗸 No death. Pendina fille in by the within 24 hours after deat To the Funeral Director Jun 18, 2009 1650 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 1200 Tollgate Road, Bel Air, MD determined (Specify) Single Family Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ca 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 19, 2009

31. Date filed (Month, Day, Year) State Registra

Zabiullah Ali, M.D.

32/Registrar's Signature

who comcleted cause of death (It in 23a

Assistant Medical Examiner

ORIGINAL

111 Penn Street, Baltimore, MD 21201

DOME

Physician /Medical Examiner Physician/Medical Examiner

Physician

/Medical

Examiner

Funeral Director

Be Completed by

ပ

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

and enter Lindheral

burial-trag

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Be Completed

Medical Certification: To

attending physician the

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician: The law requires that the death certificate be exec filled in by the funeral director, page 2 should be detact within 24 hours after death To the Funeral Director;

15240 Reistersto	wn Rd Baltimore, MD 21215
lications that caused the death. Do not enter the mode of dying, such as cardiac	
a. Respiratory tailure Due to (or as a consequence of):	
b. Due to (or as a consequence of): Due to (or as a consequence of): d.	ffusion, Atelectesis
23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	23d. Date of delivery Month Day Year
	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
	24a. Was an autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
	ath (Check only one)
Hospital: 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing H	lome 5 ☐ Residence 6 ☐ Other (Specify)
28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
ysician: To the best of my knowledge, death occurred at the time, date and place liner: On the basis of examination and/or investigation, in my opinion, death occu- and manner stated.	
Glili 200 290. License number D 24888	29d. Date signed (Month, Day, Year) June 20, 2009
rus MD 1838 Green Tires Rd #13.	5, Baltimore Min 2/208
32. Registrar's Signature	/
Server d. barks	*
	Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d

State Registrar

/Medical **Examiner** and attending physician for use as the buria Box 68760 P.O. Division of Vital Records,

Physician

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the the direct learn and the result of the profiled at once.

Maryland 21215-0036

Baltimore,

Physician: The law requires that the death certificate be executed After this certificate has been signed by funeral director, page 2 should be detact After this certificate or Attending To the Hospitar committee within 24 hours after death.

To the Funeral Director: After a final and a filled in by the fur

20

40	V	
	Cto	•

Registrar

person who completed cause of death (Item 23a) (Type, Print) 30. Name and addres

6 Could not be determined

3 Suicide

29a. Certifier (Check only one)

4 Homicide

29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, Oty or Town-State)

Hauttord

Butimore MD

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

nuisuo home

| D ∨ State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sgnature

KO 76792

5. Hwood Surtallo Bel Air ND 2014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 = For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician /Medical 10:04 PM Carter Mae Mya 2009 June 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) Age (In vrs. last birthday) **Funeral** 1 - M 2 X 0 N/AMaryland 16 May 28, 2009 **Director** Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a State 10h County 10c City Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Anne Arundel Directo Glen Burnie Maryland 10e. Street and Number 10f. Zip-Code 10g, Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with USA 21060 7607 Marcy Dr. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 承No Specify: White þ 3 Widowed 4 Divorced "natural", d other than "nau... Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. Be Carter Barbara Ann Matthew ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 803 N. Bond St., Baltimore, MD 21205 Earl L. Jackson (Grandfather) 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cameter, crematory or other place)
Baltimore Crematory
© Loudon Park 1 🗆 Burial 2 🛣 Cremation 3 🗆 Removal from State 6/18/09 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens ave., Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Necrotizing entero colitis

Due to (or as a conse dence of): **Physician** Day disease or condition /Medical resulting in death) Examiner Prematuritu 16 Days Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician and as the burial-tr Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy ☐ Live birth 2 ☐ Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4 Pregnant at time of death 5 Other (specify) signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has b autopsy performed? 2 No 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 AInpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending Injury 1 Yes 2 No investigation death. 2 Accident Director; A 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hor To the Fune completely fi (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

31. Date filed (Month, Day, Year) 232

M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Sarah Skelton 32. Registrar's Signature 600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

June 13, 2009

29c. License number

D0067337

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 11:00AM 2009 **Physician** 20 June Marcella L. Clouser /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Essex 8620 Kelso Drive Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Months Yrs Sept. 25, 1918 PA 90 170 05 2444 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 1 □Yes 2X No d other than "natural", or items 23a or 28a-f show event, the Medical Experience must be rediffed at Essex MD Baltimore Directo 10g. Citizen of What Country? 10e. Street and Number USA 21221 8620 Kelso Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Exerciting. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White Maryland 21215-0036 þ 3 ☑ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) own home Homemaker 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ellen A. Shirey Vernon L. Kulp Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2513 Bauernschmidt Drive Balto. MD 21221 Judith Caraway /daughter 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 6/24/09 Gibralter 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State St.John Gibralter 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of); Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Box 68760, Physician/Medical the IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No P.0.

þ

Completed

Be

Certification: To

Medical

Division of Vital Records,

Hospital or Attending

within 2

1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)
ibuting to death but not resulting in t	he underlying cause given in Part

Other (specify)				
derlying cause given in Part I.	23e. Did tobac	co use con	tribute to the cau	ise of death?
	1 ☐ Yes	2 No	3☐ Probably	4 🗌 Unkno

24

9 Unknown	
art II. Other significant cond	ditions contributing to death but not resulting in the underlying cause given in Part I.

I LI Tes Z	110 0 1100000, 12
la. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No

Year

25. Was case referred to medical examiner? 1 Yes 2 No	
27. Manner of Death	

Hospital: 1 Inpatient 2] ER/Outpatient	3 🗆 🛭	OOA	Other: 4	. □ Nu
28a. Date of Injury (Month, Day, Year)	28b. Time of Injury			Injury at Work? 1 □ Yes	2 🔲 l

26. Place of Dea	th (Cl	heck only one)	
r: 4 Nursing H	ome	5 Residence	6 ☐ Other (Specify,
at	Home 5/□ Residence 6 □ Other (Specify) 28d. Describe how injury occurred		

1. Natural	5 Pending
2 Accident	investigation
3 Suicide	6 Could not be determined
4 Homicide	determinet

28a. Date of Injury (Month, Day, Year)	lnjury	М	Work? 1 ☐ Yes	2 □No
28e. Place of Injury - At he building, etc. (Specific	ome, farm, stree	t, facto	ory, office	

28a.	Describe	now	injury	OCCUIT	eu			
28f.	Location ((Stre	et and State)	Numb	er or	Rural	Route	Nu

29a	Certifier
Loui	(Check only
	one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b.	Signatu	e	and	title	of	certifier	

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) 2009

30. Name and address of person who completed dause of death (Item 23a) (Type, Print)

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 01:45A owar JUNS 2009 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1emorial nion Himre If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Age (In yrs. last birthday, If Under 1 Year 9. Birthplace (State or Foreign **Funeral** Year) Months Days 1 □ M 2 □ 212-40-1183 Director March Carolina Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f sho the Medical Examiner must be redified at 1 Nes 2 No Director 21th more 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21215 Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify \$ Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 in and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Baltimore 17. Father's Name (First, Middle, Last) Middle, Maiden Surname, Mother's Name (First, Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev -age ၉ SIE 19a, Info nt's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 1 Surial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Si Jature of Funeral Service Licensee 26a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEVERE **Physician** SEPSIS Weeks /Medical Due to (or as a consequence of): Examiner 12 DAYS ON CHRONIC RENAL INSUFFICIENCY superstant of the state of the Due to (or as a consequence of) Examine certificate be executed and burial-trai Due to (or as a consequence of) attending physician for use as the buria Physician/Medical the as 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗌 Ectopic pregnancy Month Year Pregnant at time of death 5 Other (specify) n signed by the a 1 □Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 2d No 1 ☐ Yes 2 No 1 TYes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2 No 1 Dimpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760. P.O. Records, of Vital the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral Division

Medical 29b. Signature and title of certifier alam

29a. Certifier

MD

and manner stated

29c. License number AT 2439846

rcritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

19,2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ASHA SASIMANGALAM MO, UNION ME MORIAL HOSPITAL, BALTIMORE, MD 21218

State Registrar 31. Date filed (Month, Day, Year) JUN 2 3 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JUNE 19, Vear OLIVIA COOPER **Physician** Α. 2ัซื้อ9 05:39 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL CLINTON 8. Date of Birth (Month, Day, Year)
APRIL 14,1938 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🔀 F LIBERIA 71 Director 212-31-4379 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a State 10h. County 28a-f show ? is marked other than "natural", or items 23a or 28a-f shov traumatic event, I'm Mydical Examinar , ust be nothind at 1 Yes 2 No BOWIE Director MD PRINCE GEORGE'S 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20721 1701 DORAL CT. death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 □Yes 2 ☑ No
If Yes, Give
Year or Dates: 72 hours after 1 Never Married 2 Married Specify: BLACK altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 1 and 2 should be filed within : Health and Mental Hygiene. em 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC PRIVATE 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EDITH Z. KAMARA JACOB KAMARA ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is n any Injury or other traun once. 1701 DORAL CT., BOWIE, MD. 20721 CHARLES COOPER/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State GATE OF HEAVEN CEM. 7/4/09 SILVER SPRING 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CAF ITOL MORTUARY 21. Signature Funeral Service 1425 MARYLAND AVE., NE WASH., D.C. 20002 23a. Part 1. Enter the disease, or com shock, or heart failure. List only omplications that caused the death. Denot enter the mode of dying, such as cardiac or respiratory arrest, nly one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 4221 M /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Dualto (or as a echsequence of): it any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed Exami burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) P.0. ed by the a detached f signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>≨</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hospital or Attending Physician: The I 24 hours after death. Funeral Director: After this certificate h rmed? 2 X No 1 ☐Yes 2 🖺 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 6 □Could not be 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State

HIN 2 3 2009

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death **Physician** :22 PM une 200 00 /Medical City, Town Examiner give street and or Location of Death 4c. County of Death HOSPITa! Itimor Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Months Days Hours 1**X**M 2□ F Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Kaltimore 1XYes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Southridge Koac Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify. 2 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within h and Mental Hygiene. 7 is marked other than (Secondary (0-12) College (1-4or 5+) Mechanic permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surnam 17. Father's Name (First, Middle, Last) Be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryland Khineas R. Dyson Sr. Son Ballimore 5001 Archnore 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ratinore, Mary lang Vaughn C. Greene Funeral Services 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Multimore. Marulana Approximate Interval Between Onset and Death 23a. Part1. Enter the sease, or complications that caused the death. Do not enter the mod of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nmediate Cause (Final VERE METABOLIC **Physician** ACIDOSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CUTE LENAL FAILUR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760 attending physician EVELLE AMEMIA. CINKNOWN Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Ve ar 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 No Division of Vital 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Certification: To 1 Dopatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Funeral Director: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a, Certifier (Check only To the 29b. Signature and ti 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AVENUE

State Registrar MORALES

MARIA 31. Date filed (Month, Day,

DHMH 17 Rev 1/200

Registrar's Signature

BALTIMORE, MD

			_ For	State of Ma		/ Depa	rtment o	f He	alth and				.	
	Physici	an	State Registrar 1. Decedent's Name (First, Middle, L.			Cei	tificate d	of De	eath ————	2. Date of D Month	Da	ay Yes	ar	Time of Death
	/Medio Examin Funeral Director	er	4a. Facility Name (If not institution, g Good Comman for 5. Social Security Number 251-50-7432	a Itosxital	e (In yrs. las	st birthday) Yrs.	If Under 1 Ye	Lod ear li	f Under 24 Hrs.	2019	Ball	. County of D		
	D	_	Usual Residence of Decedent 10a. State 10b. County			Town or Lo							10d. li	nside City Limits ▼YYes 2 No
	with the Ma 3a or 28a-f	Il Director	MD 10e. Street and Number 1700 N. Gay	N/A Street	Bal	timo	10f. Zip Co	de 212	213			itizen of What		
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Madical Exami	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces?			Was Decedent fYes, specify 1 □Yes	of Hisp Cuban,		Specify Yes or No Rican, etc.)		Specify:	hite, etc.	ck
21215-0036	ed within 72 ho /giene. er than "natul i, the Medical	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12) I2th grade	College (1-4or 5		(Give life.	DO NOT use re	one dur etired) 1 t y	Nursi	ng	Je			ly
Maryland	should be filed withi and Mental Hygiene. s marked other thar umatic event, the M	To Be (17. Father's Name (First, Middle, La. Liston Hugee						Essie	Mae M	icWh	ite	A. Zin Con	401
	1 and 2 sho Health and tem 27 is ma		19a. Informant's Name/Relationship Bernadette Mc 20a. Method of Disposition	_		312		ıdar		ural Route Nun ue Bal Date	to,		1213	
Baltimore,	it. Pa rtmer rtant: njury		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Special Service Light)	Sity) //		ltim	ore Ce	em	1	3-2009 arch E		lto, E F/H	MD	
Ba	Physician		23a. Part1. E. Air the di ase, or co shock, in heart failure. List on Immediate Cause (Final disease or condition	mplications that cause	d the death.					Avenue c or respiratory		alto,	App	21202 proximate erval Between set and Death
68760,	/Medical Examiner in and ial-transit	ical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as b Due to (or as c Due to (or as	a conseque	ence of):								
O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant	2 🗀 Fetal o	death 3	☐ Ectopic preg ☐ Other (speci					23d. Date of Month		/ Year
rds, P.	quires that en signed by uld be deta		Part II. Other significant condition:	s contributing to death t	•		nderlying caus	se given	in Part I.					ause of death?
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r Vita	ysician is certifi director	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpat	ient 2 🗆 E	R/Outpatie	nt 3 DOA	Other:		ath <i>(Check on</i> Home 5 ☐ R		6 □ Other ((Specify)	
Division of Vital	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could no determine	be 28e. Place of In	ay, Year)		М		at es 2⊡No	28f. Location		jury occurred and Number of	or Rural Ro	oute Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Ce	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best caminer: On the basis and manner s	of examinati	rledge, dea on and/or i	th occurred at nvestigation, in	the time	e, date and pla nion, death oc	ce, and due to curred at the tin	the cause ne, date a	e(s) and mann and place, and	er as state	d. cause(s)
	To the within To the compl	Me	29b. Signature and title of certifler	Resid	-	00-) /7-00	K	icense i				Date signed (A		; Year)
	Sta Regist		30. Name and address of person when the second seco		death (item			2 b						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 7.00 PM 2009 lune 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Towso salti more HOSPICE If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 218-26-884 1 ☑ M 2 □ F March Mary lano Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Dxes 2 □ No altimore imonium 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number # 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? 1 ☑ fes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 ☑ No Specify 3 Widowed 4 Vivorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) reorge Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wills, - daughter Dwings Auare KINNY 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 109 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses JU 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS DAYS disease or condition resulting in death) Due to (or as a consequence of): VENOUS STASIS WOUNG Sequentially list conditions If any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last COMPLICATIONS OF IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Vear 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CANDIOMYOPATHY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? STROKE 24a. Was an autopsy performed? 1 Yes 2 XNo DIABLTES 2 No 1 ☐ Yes 25. Was case referred to medical examiner?

Physician /Medical **Examiner**

Physician

Examiner

Funeral

Director

show

items 23a or 28a-f

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'natural",

traumatic

S Health a

Department of Health Important; If Item 27 any injury or other the

Exeminer must be notified

Director

Funeral

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Completed

Be

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filed within 72 hours after death with the Maryland

Pages 1 and 2 should be 1 nent of Health and Mental

Maryland 21215-0036

Baltimore,

Box 68760,

P.0.

Records,

Division of Vital

/Medical

Examine

Physician/Medical

Be Completed by

Medical

Certification: To

The law requires that the death certificate be executed I or Attending Physician: after death.
Director: After this certifica filled in by 24 hours a Funeral L

within 2 To the I

State Registrar in the past 12 months? 1 ☐ Yes 2 ☐ No

5 Pending investigation

6 Could not be determined

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Decther (Specify) HOSPICE 28c. Injury at Work? 28d. Describe how injury occurred

SUPANO FALL 28f. Location (Street and Number or Rural Route Number, City or Town, State)

I BUTRICK COURT, LUTHERVILLE, MD

AT HOME 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

1 ☐ Yes 2 No

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOBERMAN, MA 555 WEST TOWSONTOWN BLUD TOWSON, MD 21204 31. Date filed (Month, Day, Year)

JUN 2 3 2009

1▼Yes 2□No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

29a. Certifier (Check only



1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

1100

28a. Date of Injury (Month, Day, Year)

-5-09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar	State of Ma	aryland		epartment of Certificate o			ental Hy	giene Reg. No	2009	20	000
	Dhysisi		Decedent's Name (First, Middle, I							2. Date of De				of Death
,,	Physicia /Medic	al	Raymond Francis 4a. Facility Name (If not institution, g				41. 07		in a CD and	June	16	, 2000		14PM
	Examin	er	Union Memorial Ho	· · · · · · · · · · · · · · · · · · ·			4b. City, Towr	Baltim			40.	. County of Deat		
ı	Funeral Director		214-24-2143	Sex 7. Age 1	e (In yrs. la	st birtho Yr	Months Day		nder 24 Hrs. urs Min.	8. Date of Bir Month, Di	th 1928		hplace (Stat untry) 1 and	e o <i>r For</i> eign
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town o	r Location						10d. Inside	City Limits
	e Mary ka-f sh	ctor	Maryland N/A			Ba	ltimore						1 🂢 Y∈	es 2□No
	with the	Director	10e. Street and Number				10f. Zip Cod		004		10g. Cit	tizen of What Co		
	ms 23	Funeral	811 S. Belnord Aver	12. Was Decedent E	ever in U.S	.	13. Was Decedent of If Yes, specify C		224 c Origin? (Spe	cify Yes or No)-	U.S.A	rican Indian,	
1215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Eventual remains be notified at	þ	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 MYes 2 N If Yes, Give Year or Dates:	o 1945 1947)-	If Yes, specify C			Rican, etc.)		Black, White Specify:	e, etc. Whit	e
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land	2 should be filed vor and Mental Hygie is marked other raumatic event, It	To Be C	17. Father's Name (First, Middle, La Elmer Eugene Ehrhart					18. M	other's Name Catheri r					
Mary	2 shour and h		19a. Informant's Name/Relationship		75	1	lailing Address (Str						Zip Code)	
	1 and 2 Health tem 27 other tr		Mr. Willy Richardson 20a. Method of Disposition	- Friend	20b. Pla		lest 24th St isposition (Name of crematory or other)			ore, Mar	<u> </u>	1 21218 .ocation - City or	Town, State	
Baltimore,	Pages ment of l ant: If ite ury or o		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Removal from State			crematory or other p	olace)	6/20	/09	Bal	itimore, M	aryland	
Ball	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.	7	21. Sign vor of Funeral Service Lie	ensee		į,	22. Name and Ad Leonard J.			5305 Ha		l Road Yaryland 2	1214	
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	mplications that caused ly one cause on each lin a	e. Tand	id	in farc		h as cardiac o			8	Approxim Interval E Onset an	etween d Death
00/00	ifficate be executed g physician and ss the burial-fransit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a									<u> </u>	ee)cs
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Records, 1	law requires that the d as been signed by the 2 should be detached	þ	Part II. Other significant conditions	contributing to death bu	it not resul	ting in th	e underlying cause	given in P	Part I.		Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 ☑ Probably 4 □ Unknown			
necc	The law re ate has be page 2 sho	Completed								24a. Was auto perfo	psy ormed?/	death?	topsy finding completion o	gs available f cause of
VII	ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:				Other:	Place of Death	(Check only	one)			
10 HO	ding Phys h. After this funeral di	tion: To	1 Yes 2 No 27. Mannar of Death 1 Natural 5 Pending 2 Accident investigati	28a. Date of Injur (Month, Day	ry :	R/Outpa 28b. Tim Inju	ne of 28c. In	ojury at Vork? □Yes	2	ne 5 Res		6 ☐ Other (Spe iry occurred	cify)	
DIVISION	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 or	Certification: T	3 Suicide 6 Could not determine	be 290 Place of this			, street, factory, office				(Street and Number or Rural Route Number, own, State)			umber,
,	ne Hospit n 24 hour ne Funera	edical (29a. Certifier 1 ☐ Certifying (Check only one) 2 ☐ Medical Ex	Physician: To the best of aminer: On the basis of and manner sta	examinati	rledge, o on and/o	leath occurred at th or investigation, in n	e time, da ny opinion,	te and place, a	and due to the	cause(s , date an	s) and manner and place, and due	s stated. e to the caus	e(s)
	To th To th Comp	Me	29b. Signature and title of certifier	7 11.			29c. Lice	ense numb	ber odl.	/	29d. Da	ate signed (Mont	h, Day, Year)
			30. Name and address of person wh	o completed cause of de atotai,	eath (Item	23a) (Ty	pe, Print)	CT:	38996 Emorio	0	Jun	1e 16,	1009	
	Sta Registra		31. Date filed (Month, Day, Year)	32. Registra	ar's Signatu	re	Union J	(()	- MOY 10	AI M	19pt	Lab /		